

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A 15E 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08246

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u>	STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u>	LENGTH OF STAY (in this place) <u>29 hrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>	STREET ADDRESS (If rural give location) <u>637 MARYLAND AVENUE</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>EUNICE EUDORA APPLE</u>		<u>Sept 5 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 26, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES NORRIS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Creek Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Chart</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>260 X IMMEDIATE CAUSE (A) <u>Eutero Colitis</u></u>			<u>6 days</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
<u>Diabetes mellitus</u>			<u>unknown</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Atherosclerotic heart disease</u>			<u>3 years</u>
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 3</u> 19 <u>55</u> to <u>Sept 5</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 5</u> 19 <u>55</u> , and that death occurred at <u>9:02 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ralph W. Baccin</u>		ADDRESS (Street, city, town, state) <u>M.D. 62 George Cumberland Md</u>	
DATE SIGNED <u>9-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>9/7/55</u>	NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
24. REC'D BY REGISTRAR <u>Sept. 7, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter L. Frantz, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Jr.</u>	ADDRESS <u>Cumberland, Md</u>

BOREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8278

CERTIFICATE OF DEATH

08247

Reg. Dist. No. 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>43 Westernport</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		CITY OR TOWN <u>43 Westernport</u>		CITY OR TOWN <u>43 Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>81 Main St</u>				STREET ADDRESS (If rural give location) <u>81 Main St</u>			
3. NAME OF DECEASED (Type or Print) <u>Donald Marshall Atkins</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>28 July 1918</u>	9. AGE last birthday <u>38</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Lloyd M. Atkins</u>				14. MOTHER'S MAIDEN NAME <u>Grace Evers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>234-26-9552</u>		17. INFORMANT & ADDRESS <u>81 Main St</u> <u>Mrs Donald Atkins, Westernport Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
430.1 IMMEDIATE CAUSE (A) <u>Chronic Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u> </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u> </u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1955</u> to <u>Sept 2, 1955</u> that I last saw the deceased alive on <u>Sept 2, 1955</u> and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James A. Shepherd Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Westernport W. Va.</u>		DATE SIGNED <u>9-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5 Sept 55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR <u>9-5-55</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>		ADDRESS <u>Westernport, Md.</u>	

CERTIFICATE OF DEATH

DATE

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Place of birth		6. Date of death	
7. Place of death		8. Cause of death		9. Manner of death	
10. Signature of physician		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of registrar		14. Signature of funeral director		15. Signature of family	

BUREAU V. S.

SEP 8 1955

RECEIVED

8239

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u> COUNTY <u>ALLEGANY</u>		CITY <u>CUMBERLAND</u>		CITY <u>CUMBERLAND</u>	
CITY <u>CUMBERLAND</u>		LENGTH OF STAY <u>1 mon. 3 wks</u>		CITY <u>CUMBERLAND</u>		CITY <u>CUMBERLAND</u>	
TOWN <u>CUMBERLAND</u>				TOWN <u>CUMBERLAND</u>		TOWN <u>CUMBERLAND</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SACRED HEART HOSPITAL</u>				STREET ADDRESS <u>226 EMILY STREET</u>			
3. NAME OF DECEASED (Type or Print) <u>MAMIE L. ATKINSON</u>				4. DATE OF DEATH <u>9-28-55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>11-7-80</u>	
9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES O. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET NAUGHTON MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Nancy Newcomer Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450. IMMEDIATE CAUSE (A) <u>gum abscess</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>9-28-55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9-28-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-28-55</u> to <u>9-28-55</u> that I last saw the deceased alive on <u>9-28-55</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. J. J. Johnson</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>9-28-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>9-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Percy Cem.</u>		LOCATION (City, town, or county) (State) <u>Frestburg, Md.</u>	
24. REC'D BY-REGISTRAR <u>Sept. 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>			

Within corporate limits

INSTRUCTIONS

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VS 15C-155 10M

CERTIFICATE OF DEATH

5833

THIS DEATH

WAS

REPORTED

ON

2 -

DATE

TIME

DECEASED

BUREAU V. 1

OCT 3 1955

RECEIVED

Without corporate seal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08249
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cumberland</u>		<u>7 yrs.</u>		TOWN <u>Cumberland</u>		<u>02</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>128 Hanover St.</u>				STREET ADDRESS (If rural, give location) <u>128 Hanover St.</u>			
3. NAME OF DECEASED: (First) <u>Samuel</u>		(Middle) <u>E.</u>		(Last) <u>Baechtel</u>		4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>16</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Dec. 20-1874</u>	
9. AGE last birthday: <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Pct. Conductor Pa. R. Ry.</u>		11. BIRTHPLACE (State or foreign country): <u>Md. Washington Co U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>716-09-9390</u>		17. INFORMANT & ADDRESS: <u>(son) Harry Baechtel, Berryville, Va.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>		DUE TO		<u>sudden</u>	
Antecedent cause(s) (b) <u>Coronary sclerosis</u>		DUE TO		<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, of street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>H.V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Sept. 16-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		24. FUNERAL DIRECTOR <u>Louis Stein, Inc. Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. S.

08250

8241

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>W. Va</u>	COUNTY <u>Mineral</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02</u> TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>5 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ridgeley</u>	<u>85x.3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>62</u> <u>Sacred Heart Hospital</u>		STREET ADDRESS (If rural give location) <u>Route 1</u>	
3. NAME OF DECEASED (Type or Print) <u>Harry</u> <u>Holiday</u> <u>Barley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept</u> <u>30</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 12, 1884</u>
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.F.W. Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Winchester, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Deceased Louis L. Barley</u>		14. MOTHER'S MAIDEN NAME <u>Florence Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes, 1898-1902</u>		16. SOCIAL SECURITY NO. <u>710-09-5962</u>	
17. INFORMANT & ADDRESS <u>Wife- Cora I. Barley, Ridgeley W. Va.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>331X Cerebral hemorrhage</u>			<u>5 days</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive and arteriosclerotic changes</u>			<u>2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-25</u>, 19<u>55</u>, to <u>9-30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>9-30</u>, 19<u>55</u>, and that death occurred at <u>5:07 PM</u>, from the causes and on the date stated above.			
SIGNATURE <u>Ralph W. Baerlin</u>		ADDRESS (Street, city, town, state) <u>M.D. 62 Greene St. Cumberland, Md</u>	
DATE SIGNED <u>10-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Trout, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

1912

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Death		Place of Death		Time of Death	

BUREAU V. S.

OCT 9 1912

RECEIVED

INSTRUCTIONS

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08251

8279.

CERTIFICATE OF DEATH

Reg. Dist. No. ... 6

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
43 TOWN <u>WESTERNPORT</u>		<u>60 yrs</u>		TOWN <u>WESTERNPORT</u>		+	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
314 <u>MD</u> Ave				314 <u>MD</u> Ave		1	
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
James Henry Bell				Sept 15 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
Male	White	Widowed	April 30, 1861	94 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Miner - Ret Coal Mine				Newburg, W. Va.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Amos Bell				SARAH CURRANCE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mrs Louis Hicks Westernport 314 MD Ave			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>not specified as Rheumatic</u>				Chronic Myocarditis and Myocardial Degeneration		2 Years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 14</u> , 1955, to <u>Sept 15</u> , 1955, that I last saw the deceased alive on <u>Sept 14</u> , 1955, and that death occurred at <u>3:24 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>James B. Wilson</u>		<u>Piedmont, W. Va.</u>		<u>Sept 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-18-55</u>		<u>Memorial Park</u>		<u>Frostburg MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-17-55</u>		<u>Mrs Jean C. Kelly</u>		<u>C. Boal</u>		<u>MD Westernport</u>	

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08252

8291

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Lonaconing</u>		<u>52 yrs</u>		TOWN <u>Lonaconing</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 JACOBSON ST</u>				STREET ADDRESS (If rural give location) <u>90 JACOBSON ST</u>			
3. NAME OF DECEASED (Type or Print) <u>William Henry Berry</u>				4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>20 July 1880</u>		9. AGE last birthday <u>75</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>BARTON, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Berry</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Quinn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Was, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>44-039022</u>		17. INFORMANT & ADDRESS <u>James Berry, Lonaconing MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>				<u>10 yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 4</u> 19<u>55</u> to <u>Sept 4</u> 19<u>55</u>, that I last saw the deceased alive on <u>Sept 4</u> 19<u>55</u>, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George R. Ruland</u> M.D.				ADDRESS (Street, city, town, state) <u>Lonaconing Md</u>		DATE SIGNED <u>9-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>	
24. REC'D BY REGISTRAR <u>9-7-55</u>		REGISTRAR'S SIGNATURE <u>Gusette M. Dool</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. T. Ruppert</u>		ADDRESS <u>Md.</u>	

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8242

CERTIFICATE OF DEATH

08253

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (In this place) 6 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS 12 FIFTH STREET (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) STANLEY S. BURKE				4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 4 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAY 25 1904	9. AGE last birthday 55 51 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Ridgely		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BURKE				14. MOTHER'S MAIDEN NAME MARGARET DIEHL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. 214-32-3018		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
581.0 IMMEDIATE CAUSE (A) Cirrhosis of Liver						2 yrs	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 27/7/53, 19 to 9/9/55, 19, that I last saw the deceased alive on 9/3/55, 19, and that death occurred at 5:15 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 9-7-55		NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
				LOCATION (City, town, or county) Cumberland, Md.		(State)	
24. REC'D BY REGISTRAR Sept. 7, 1955		REGISTRAR'S SIGNATURE Walter R. Featz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M



08254

8280

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>allegany</i>		MARYLAND		STATE <i>Ind</i>		COUNTY <i>alleg</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Frostburg</i>		<i>13 hrs 45 min</i>		TOWN <i>Frostburg</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Miners Hospital</i>				STREET ADDRESS (If rural give location) <i>Miners Hospital</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Baby Boy Collette</i>				<i>Sept 19 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>		<i>Sept. 18 '55</i>	<i>—</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Infant</i>				<i>Infant</i>		<i>Frostburg, Ind.</i>	
12. CITIZEN OF WHAT COUNTRY?				<i>U.S.A.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Robert O. Collette</i>				<i>Mary Alice Carter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Mary O. Collette Rt. 1 Frostburg, Ind.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
77 IMMEDIATE CAUSE (A)				<i>Premature birth (6 hrs)</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE D.D INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>9-15</i> , 19 <i>55</i> , to <i>9-19</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>9-19</i> , 19 <i>55</i> , and that death occurred at <i>6:15 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<i>H.C. Siehl</i>		<i>Frostburg, Ind.</i>		<i>7/19/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9-20-55</i>		<i>Frostburg Park</i>		<i>Frostburg, Ind.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>9-19-55</i>		<i>Mrs. Nancy H. Roe</i>		<i>J. R. Winst.</i>		<i>Frostburg, Ind.</i>	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

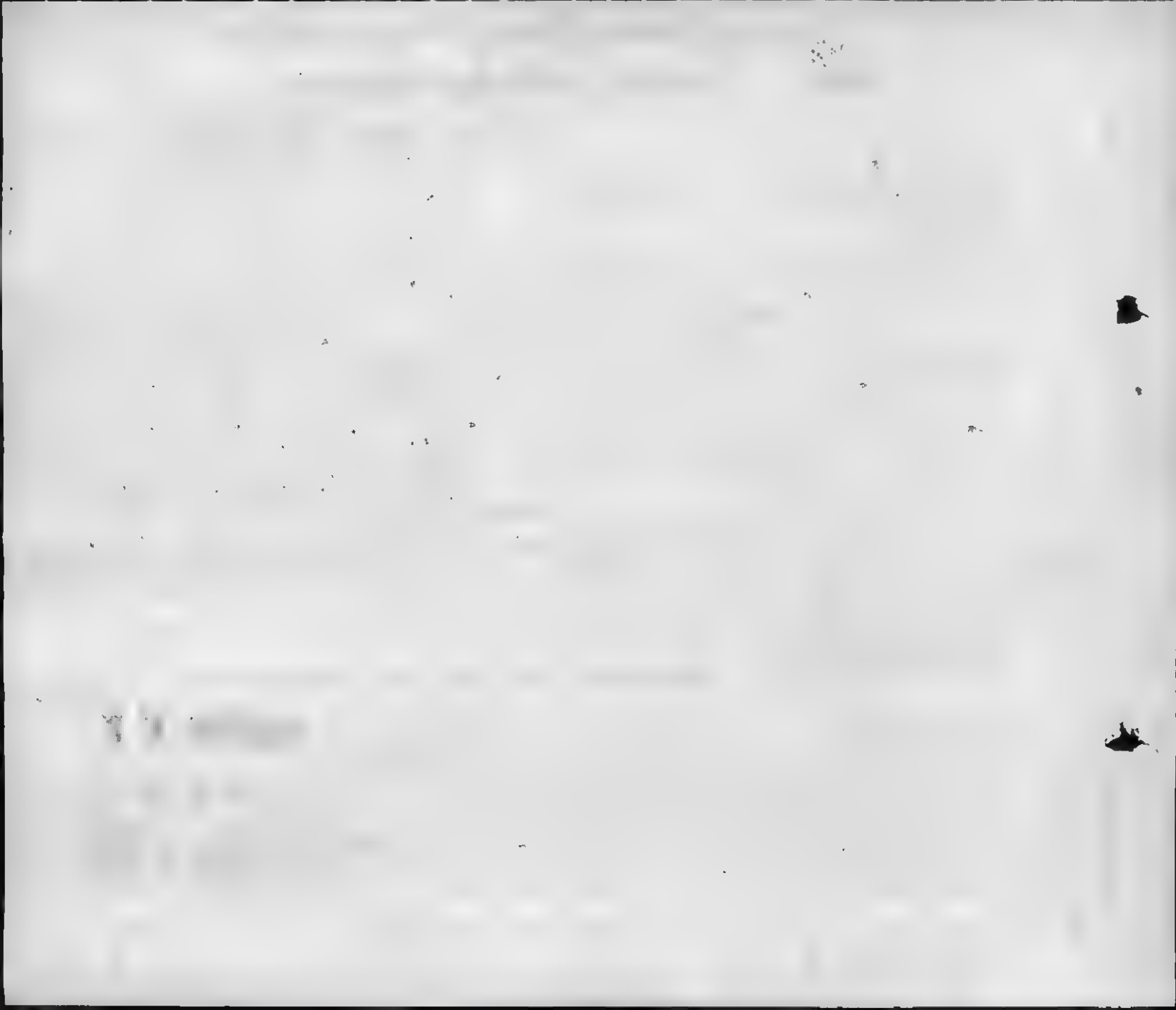
8281

CERTIFICATE OF DEATH

08255

Reg. Dist. No. 17

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Alleg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Frederickburg</u>		<u>14 hrs.</u>		TOWN <u>Frederickburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. 1, F.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Baby Girl Collette</u>				<u>Sept 19 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept. 18 '55</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Frederickburg, Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Robert C. Collette</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Collette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary A. Collette, Rt. 2, Ind.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>Premature birth (6 mos.)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-18</u> , 19 <u>55</u> , to <u>9-19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>55</u> , and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>H.C. Diehl</u>				ADDRESS (Street, city, town, state) <u>M.D. Frederickburg, Ind.</u>		DATE SIGNED <u>9/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Frederickburg New Park</u>		LOCATION (City, town, or county) (State) <u>Frederickburg, Ind.</u>	
24. REC'D BY REGISTRAR <u>Mr. Harvey N. R. &</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Hurst</u>		ADDRESS <u>Frederickburg, Ind.</u>	
DATE <u>9-19-55</u>							



MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Id.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Cumberland</u>	<u>4 1/2 hrs.</u>	TOWN <u>Cumberland</u>	<u>02</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>		STREET ADDRESS (If rural, give location)	<u>509 Pine Ave.</u>
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH		
<u>David H. Crabtree</u>	<u>Sept. 7 1955</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Jan. 22-1943</u>
9. AGE last birthday: <u>12</u> yrs.	10. BIRTHPLACE (State or foreign country): <u>Id.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
12. FATHER'S NAME: <u>Leo Crabtree</u>	13. MOTHER'S MAIDEN NAME: <u>Alberta Little</u>		
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	15. SOCIAL SECURITY No.: <u>none</u>	16. INFORMANT & ADDRESS: <u>(mother) Mrs. Alberta Crabtree, Cumberland, Id.</u>	

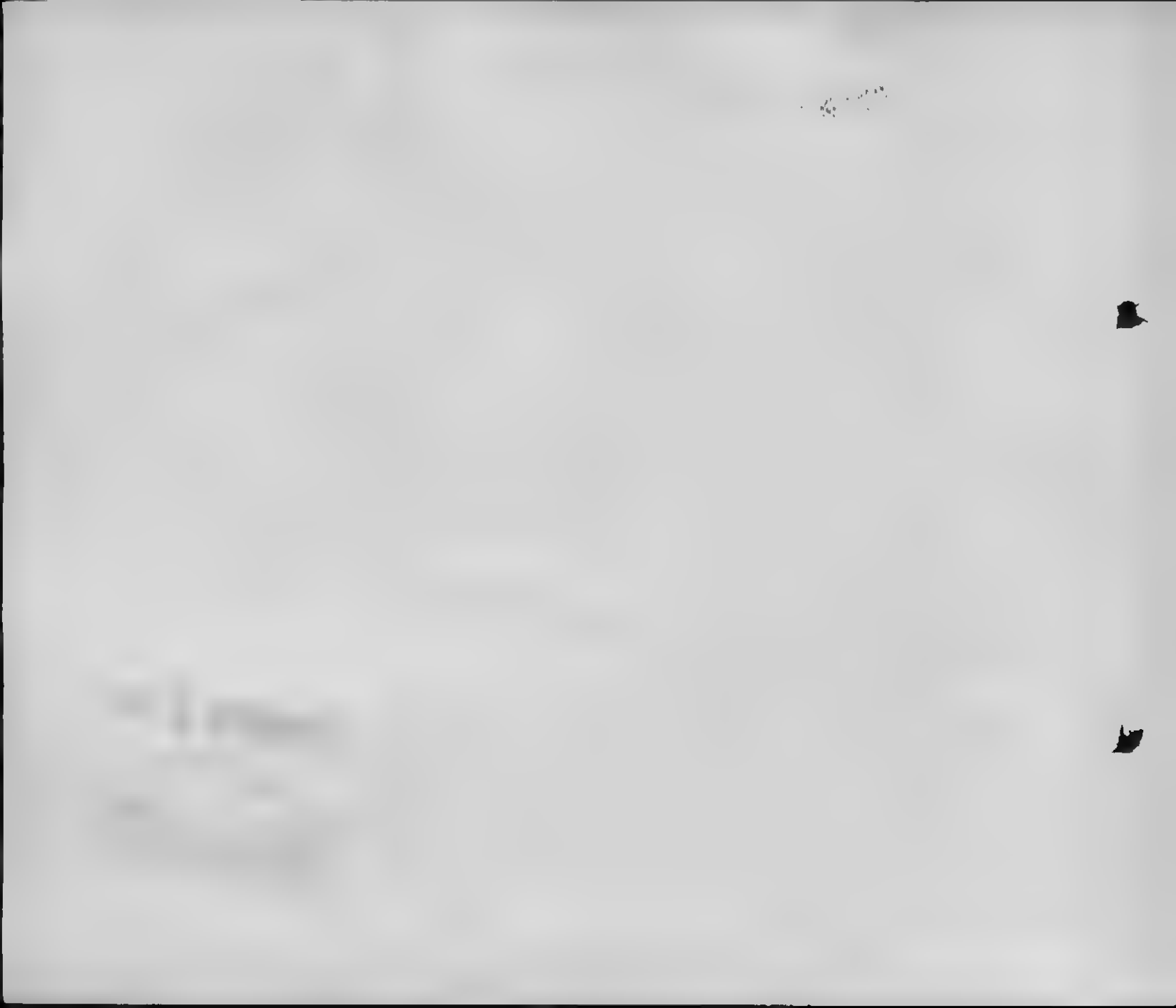
17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		<u>4-1/2 hrs</u>
(a) Immediate cause <u>Intracranial hemorrhage</u>		
(b) Antecedent cause(s) <u>a 38 caliber revolver bullet wound in forehead</u>		
(c) stating underlying cause last <u>exit, occipital region. Accidentally discharged.</u>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>Sept. 7/55</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (City or town) (County) (State) <u>Cumberland Allegany Id.</u>
21d. TIME (Month) (Day) (Year) <u>Sept. 7/55</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>laying with revolver, accidentally discharged.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>H. V. Doring M.D.</u> M. D. CHIEF MEDICAL EXAMINER <u>Sept. 8-1955</u>		

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Sept. 10, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Ann's Cemetery</u>	LOCATION (City, town, or county) (State): <u>Cumberland, Maryland</u>
DATE REC'D BY LOCAL REG.: <u>Sept. 9, 1955</u>	REGISTRAR'S SIGNATURE: <u>Walter R. Hantz, M.D.</u>	24. FUNERAL DIRECTOR: <u>John J. Sifers</u>	ADDRESS: <u>"</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The consent age is especially important. Physicians: please write the causes of death clearly and legibly.



8244

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>				STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>D.O.A. Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>525 Pine Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ALMEDIA BURDINE DAVIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 2 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 14, 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Twintown, Md. Alleg. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Newell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>H.O. Davis, Cumberland, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arteriosclerotic Heart Disease</u>				<u>at least</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>with aortic Filariation</u>				<u>6 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Sept 1</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u> to <u>Sept 2, 1955</u> , that I last saw the deceased alive on <u>Sept 1, 1955</u> , and that death occurred at <u>41 Green St., Cumberland Md.</u> on <u>Sept 2, 1955</u> M. from the causes and on the date stated above.							
SIGNATURE <u>B. M. Schindler</u>		M.D. <u>41 Green St., Cumberland Md.</u>		DATE SIGNED <u>9/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Sept 4, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Davis Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Allegany County, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept 4, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frank, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



8245
CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Allegheny</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Allegheny</u>
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>60 yrs.</u>	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>325 Arch St</u>		STREET ADDRESS (If rural, give location) <u>325 Arch St</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rose Catherine Herlan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 29 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 23, 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Riggelman</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Catherine Ebersole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Mrs Arthur Bland 325 Arch St</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident - Apoplexy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Arteriosclerosis Cerebrovascular Disease</u>			
(C)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While at work Not while at work			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 28</u> , 19 <u>55</u> , and that death occurred at <u>5:40</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>H. C. Hunter, M.D.</u>		ADDRESS (Street, city, town, state) <u>133 Wagon Ave, Cumberland, Md</u>	
DATE <u>9/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Oct 2, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
24. REC'D BY REGISTRAR <u>Oct 4, 1955</u>	REGISTRAR'S SIGNATURE <u>Walter R. Gantz, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>	ADDRESS <u>Cumberland Md</u>

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2000 4-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8246

CERTIFICATE OF DEATH

08259

Reg. Dist. No. 4

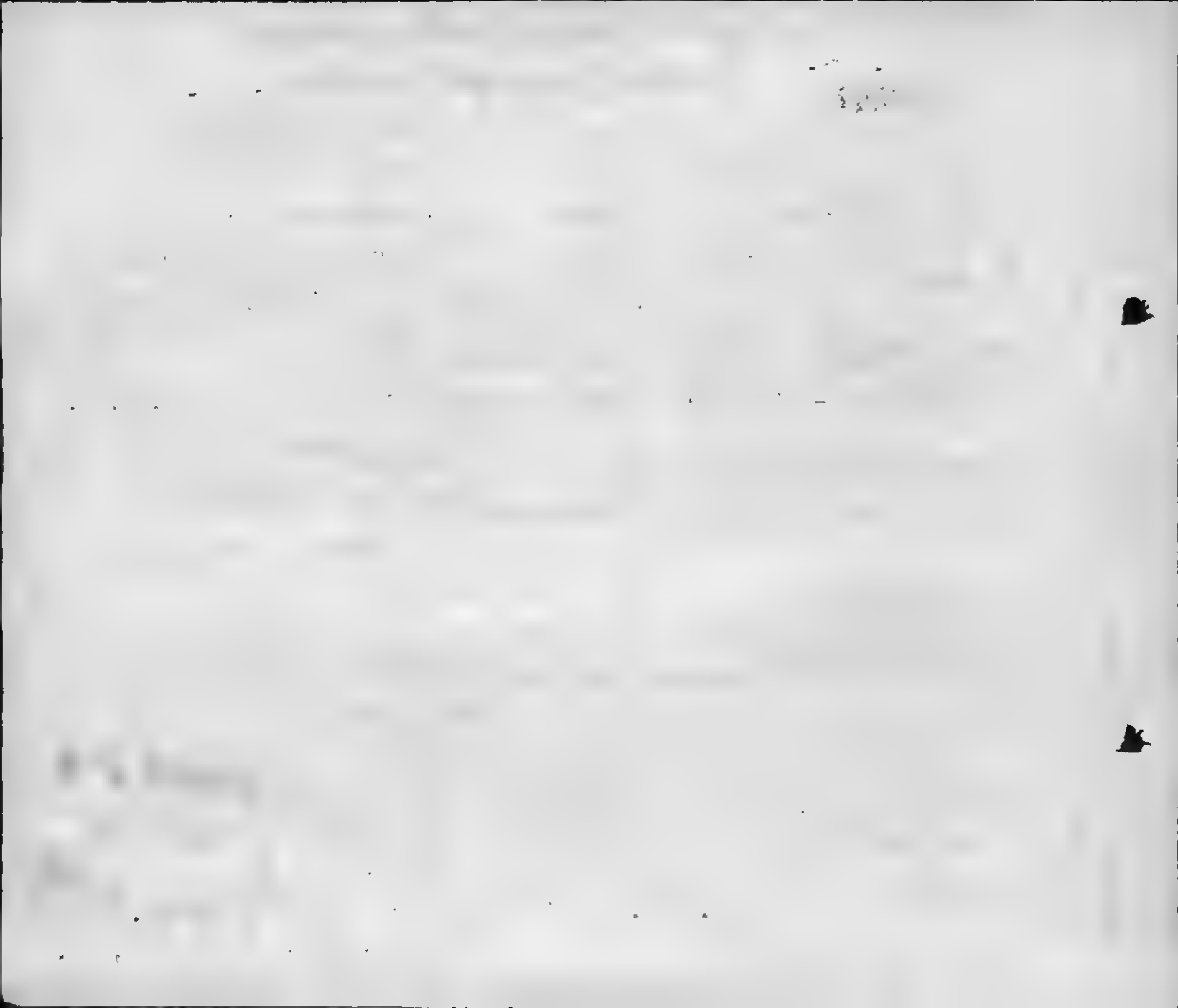
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		LENGTH OF STAY (in this place) 5/12/52		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71 Allegany County Infirmary				STREET ADDRESS (If rural give location) 439 Cumberland Street			
3. NAME OF DECEASED (Type or Print) Mary H. Dobbie				4. DATE OF DEATH September 28, 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 11/25/1873	9. AGE last birthday 81 yrs.	10. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Milliner			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel Dobbie				14. MOTHER'S MAIDEN NAME Alice McGee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Allegany County Infirmary Records			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) Chronic Myocardial Degeneration				INTERVAL BETWEEN ONSET AND DEATH ?			
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Secondary Anemia				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Chronic Nephritis				?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 13, 1953, to Sept. 28, 1955, that I last saw the deceased alive on Sept. 28, 1955, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
SIGNATURE James B. DeLoe				M.D. 49 Prince St.		DATE SIGNED 9-29-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Oct. 1st. 1955		NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. REC'D. BY REGISTRAR Sept. 30, 1955		REGISTRAR'S SIGNATURE Walter R. Fantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15 1-55 104



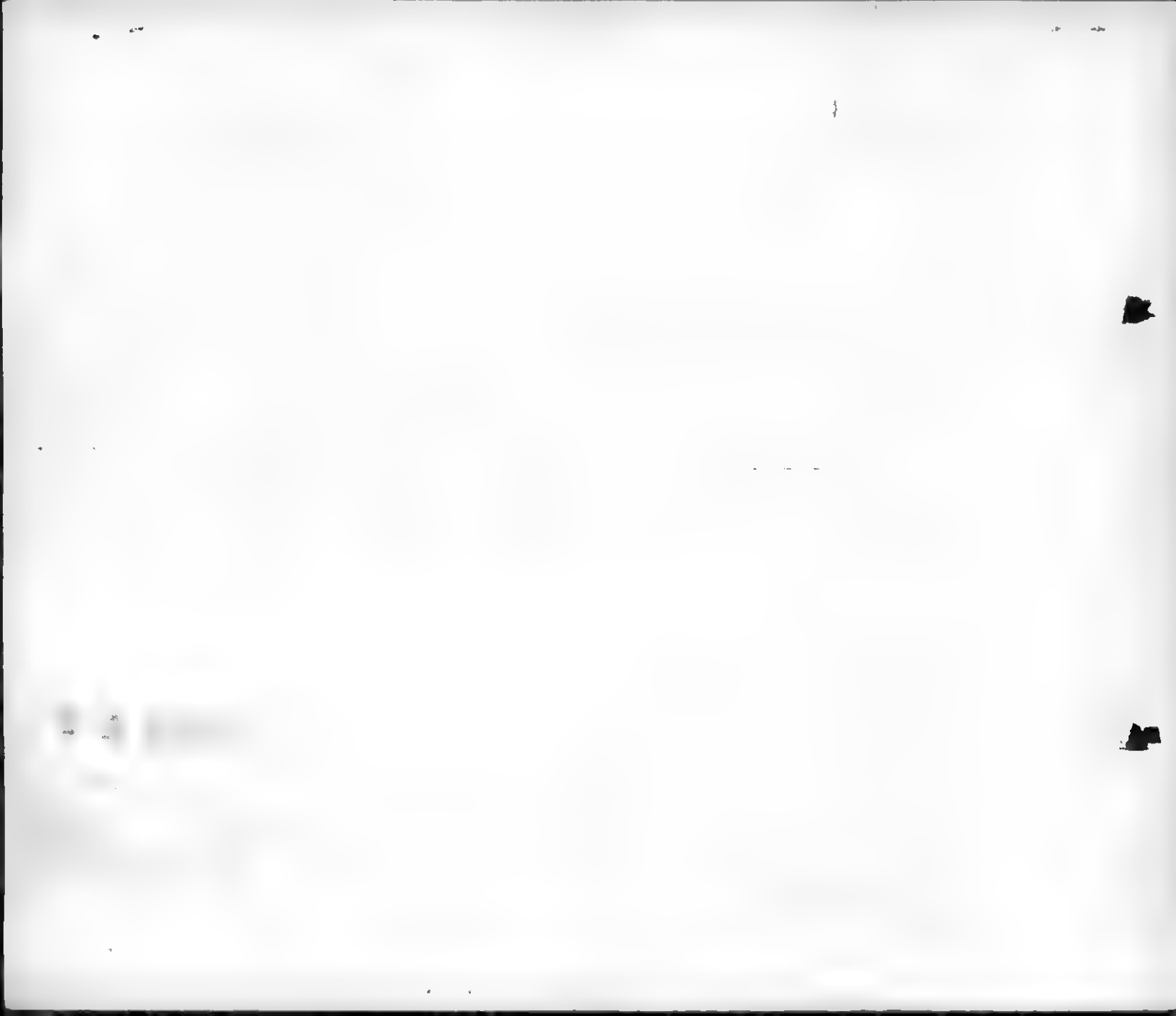
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08260
8282 CERTIFICATE OF DEATH Reg. Dist. No. 6

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>	LENGTH OF STAY (in this place) <u>8 years</u>	CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Westernport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stoney Run Road</u>		STREET ADDRESS (If rural give location) <u>Stoney Run Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Julia Alice Droll</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept 7 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 22, 1894</u>
9. AGE last birthday: <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Flintstone Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>David Kifer</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Shipway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Westernport, Md.</u>		18. <u>Joseph Droll, Stoney Run Road</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>14 Days</u>	
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis & Hypertension</u>		<u>5 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 24, 1955</u> , to <u>Sept. 7, 1955</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 1955, and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul B. Wilson</u>		DATE SIGNED <u>Sept. 9, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Bloomington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bloomington, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-10-55</u>		REGISTRAR'S SIGNATURE <u>Mr. John C. Kelly</u>	
24. FUNERAL DIRECTOR <u>E. S. Boal</u>		ADDRESS <u>Westernport, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1. While this certificate is being filled out, the third copy of this certificate should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08261

8247

CERTIFICATE OF DEATH

Reg. Dist. No. 4

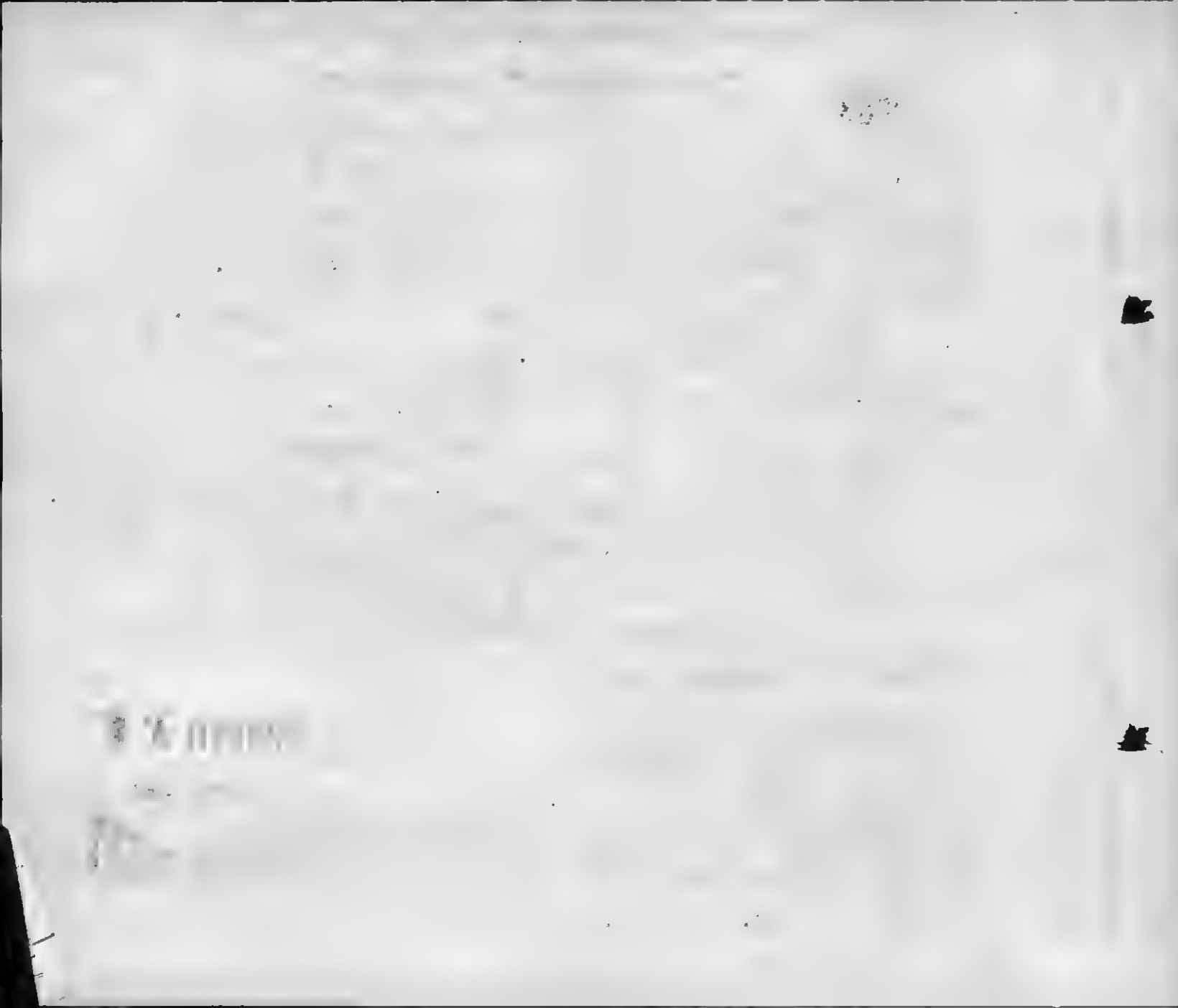
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place)		CITY OR TOWN <u>Cumberland</u>		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>212 Schley St</u>				STREET ADDRESS <u>212 Schley St.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Bridget Ellen Fahey</u>				4. DATE OF DEATH <u>Sept. 18 19 55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Nov. 16, 1868</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		9. AGE last birthday <u>86</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Oakland, Md.</u>	
13. FATHER'S NAME <u>Micheal Carney</u>				14. MOTHER'S MAIDEN NAME <u>Bridget Haeghan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Micheal Fahey, Westernport, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				7 days			
422.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerotic Cardiovascular disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 54</u> to <u>Sept 55</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Walter R. Prouty, M.D.</u>				DATE SIGNED <u>9/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 21/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) <u>Westernport, Alleg. Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 19, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Prouty, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Fredlock Jr.</u>		ADDRESS <u>Westernport, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



8292

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08262
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

1. PLACE OF DEATH:

COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town) BARTON LENGTH OF STAY (in this place) 84 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN BARTON
STREET ADDRESS (if rural, give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

MATILDAFoutz

OF DEATH

Sept41955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FemaleWhiteWidow14 April 187184 yrs.MonthsDays

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

DomesticOwn homeBARTON, MDU.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Dennis PrestonCATHERINE Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

No—NONEJohn Foutz, BARTON, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X
Immediate cause(a) Myocardial Failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) cardiovascular-renal disease

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH
Natural3 years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

4

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town),

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

8/16/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial5-7-55MT. View CemeteryMoscowMd.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5-7-55Mr. James C. KellyE. D. Boul.WESTPORT, Md.

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8283

CERTIFICATE OF DEATH

Reg. Dist. No. 9

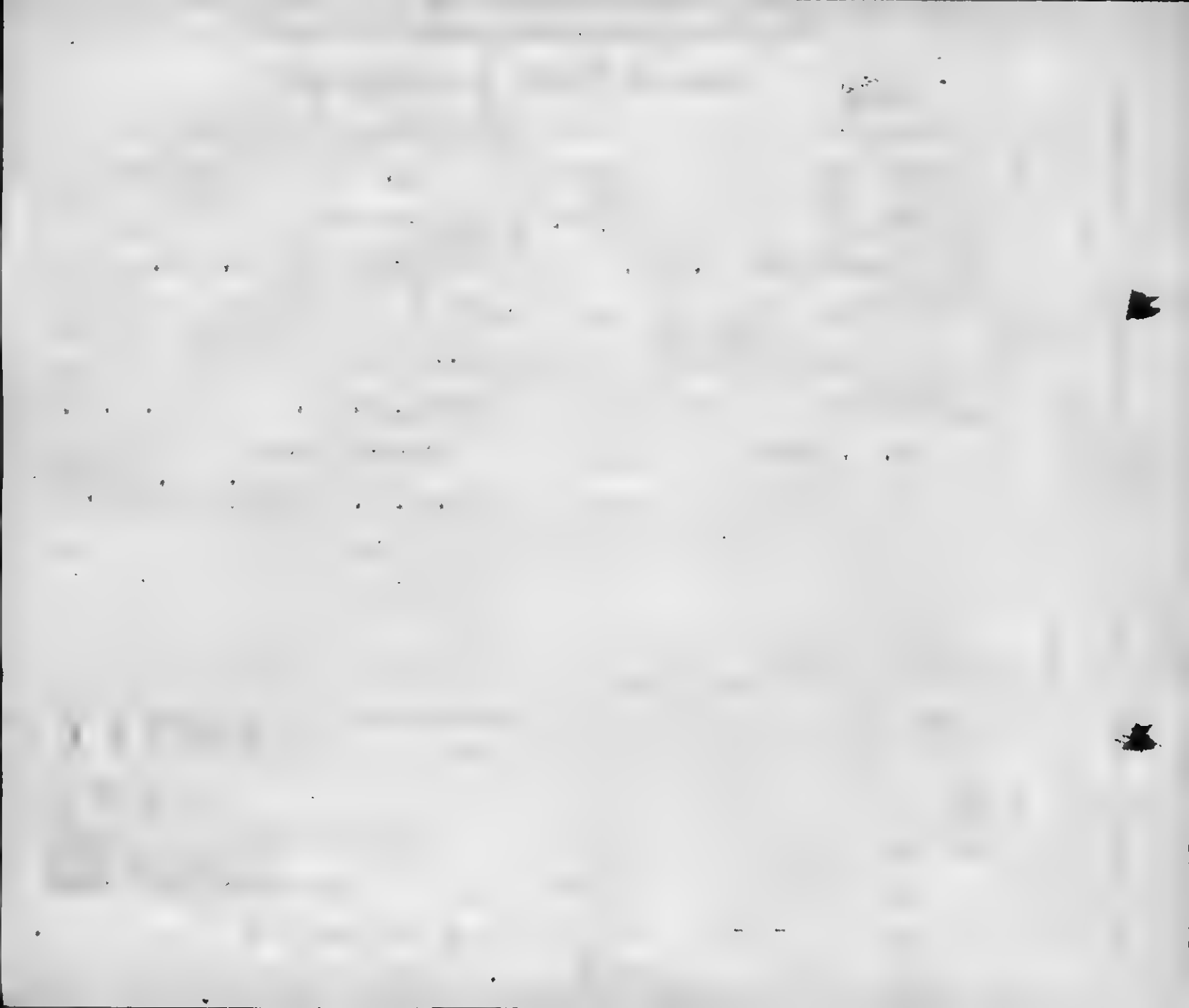
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY OR TOWN <u>22 Frostburg</u>		LENGTH OF STAY (in this place) <u>15yrs.</u>		CITY OR TOWN <u>Frostburg</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington St. Ext.</u>				STREET ADDRESS <u>Washington St. Ext.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ella Grace Gattens</u>				4. DATE OF DEATH <u>9 18 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>May 14th. 1865</u>	
9. AGE last birthday <u>90 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Webster, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>W. M. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>W. E. Gattens, Son Md. Washington St. Ext. Frostburg</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153x IMMEDIATE CAUSE (A) <u>Carcinoma - sigmoid colon</u>				<u>Several Months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Colon</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 14, 1955</u> to <u>Sept. 14, 1955</u> , that I last saw the deceased alive on <u>Sept. 14, 1955</u> , and that death occurred at <u>9:17 A.M.</u> from the causes and on the date stated above							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Frostburg, Md.</u>		DATE SIGNED <u>9-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-20-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		LOCATION (City, town, or county) (State) <u>Barton Md.</u>	
24. REC'D BY REGISTRAR <u>9-20-55</u>		REGISTRAR'S SIGNATURE <u>Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pearl H. Mattingly</u>		ADDRESS <u>Frostburg Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1. **Attending Physician or Hospital:** The law requires that the death certificate be executed within 24 hours after death. The **body** copy may be retained by the hospital or attending physician.

INSTRUCTIONS

1

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

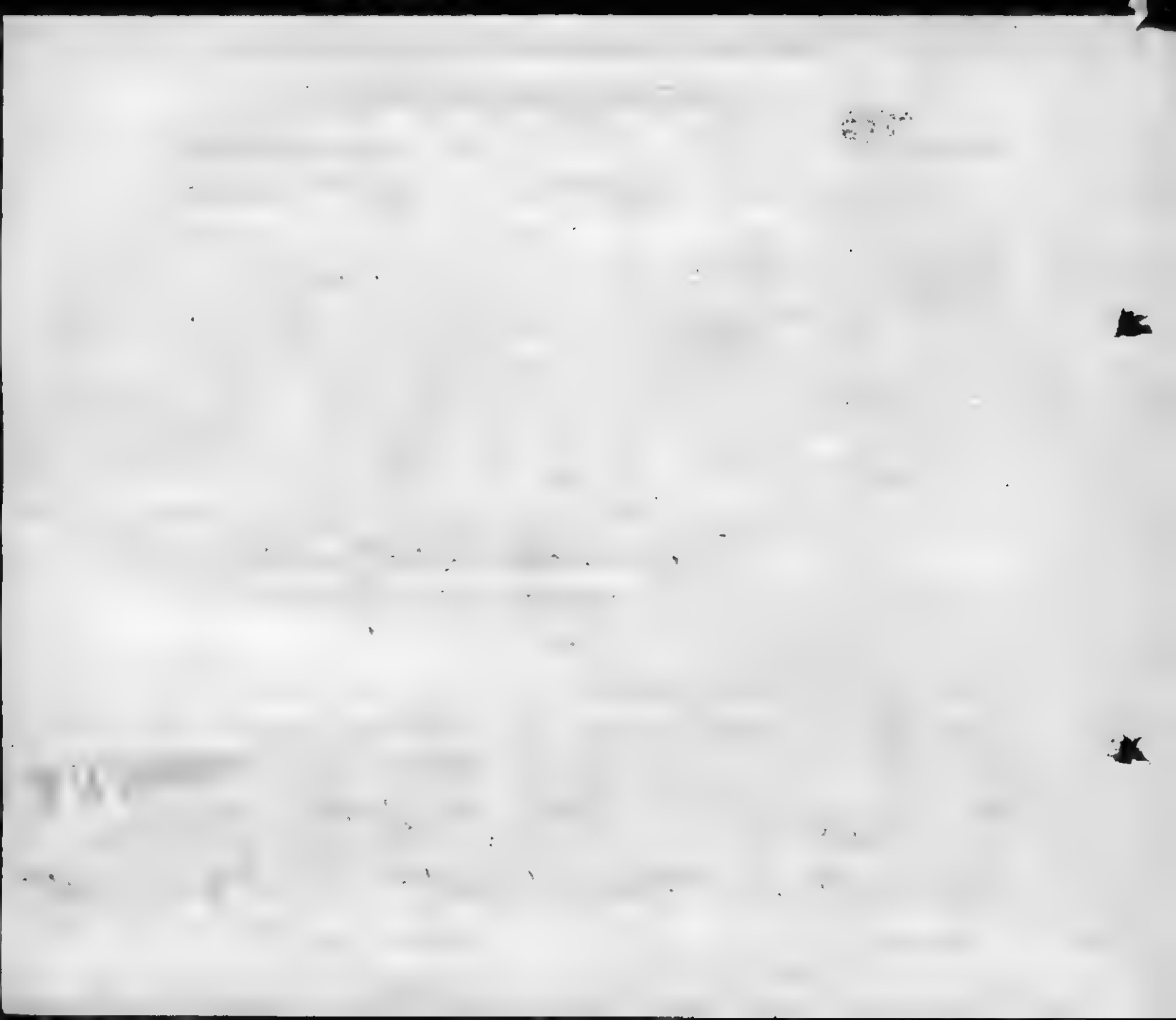
08264

CERTIFICATE OF DEATH

Reg. Dist. No. 4

8248

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		<u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL CUMBERLAND, MD.</u>				STREET ADDRESS <u>RT.#1, HOMEWOOD ADDITION</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARGARET</u> (Middle) <u>GORDON</u> (Last)				(Month) <u>SEPT.</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 7, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN POWELL</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES GRIFFITHS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Harvey Gordon, Cumberland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Rheumatic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 7, 1955</u> to <u>Sept 10, 1955</u> , that I last saw the deceased alive on <u>Sept 10, 1955</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George M. Brown</u>		M.D. <u>Cumberland Md.</u>		DATE SIGNED <u>Sept 11, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>L. yborger</u>		LOCATION (City, town, or county) (State) <u>Buffalo Mills Pa</u>	
24. REC'D BY REGISTRAR <u>Sept. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Zeigler</u>		ADDRESS <u>Hydsonman Pa</u>	



CERTIFICATE OF DEATH

08265

Reg. Dist. No. 4

8249

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		12 days		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
SACRED HEART HOSPITAL				518 LOUISIANA AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
JOHN FRIDEN GRIFFITH				9-30-55			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
MALE		WHITE		MARRIED		11-25-1875	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Engineer		West-Md. R.R.		WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES GRIFFITH				ELIZABETH Scott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
				None		CLARET	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				13 Bronchogenic Carcinoma			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1 year	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 1st 55 to Sept 29, 1955, that I last saw the deceased alive on Sept 29, 1955, and that death occurred at 7:55 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
R. W. Treaskie, Jr.				M.D. Cumberland, Md.		9/30/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 2, 1955		Hillcrest Bur. Park		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
R. W. Treaskie, Jr.		Walter L. Hauf, M.D.		John J. Hafer, Cumberland, Maryland			

VS A15C 1-55 10M

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Corporate limits

8250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08266

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Bedford</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cumberland</u>				TOWN <u>Cumberland</u> (rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dead on arrival at the Sacred Heart Hospital.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. 3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Helvin Wilson Crowden</u>				<u>Sept. 12 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>July-15-1912</u>	<u>43</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Contract Worker</u>		<u>Howell Coal Co.</u>		<u>Bedford Co. Pa.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Crowden</u>				<u>Ethie Hardman</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>220-16-1372</u>		<u>(wife) Mary Myrtle Crowden, R.F.D. 3</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a).....		Coronary occlusion		sudden.....	
DUE TO				about 5	
Antecedent cause(s) (b) ...		Coronary sclerosis		years ..	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO		about 5	
(c) Chronic myocarditis				years,	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>H.V. Deming M.D.</u>		<u>H. V. Deming M.D.</u>		<u>Sept. 12-1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Sept. 15, 1955</u>		<u>Friendship Cemetery</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Sept. 14, 1955</u>		<u>Walter R. Frantz, M.D.</u>		<u>John J. Sifer, Cumberland, Maryland</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

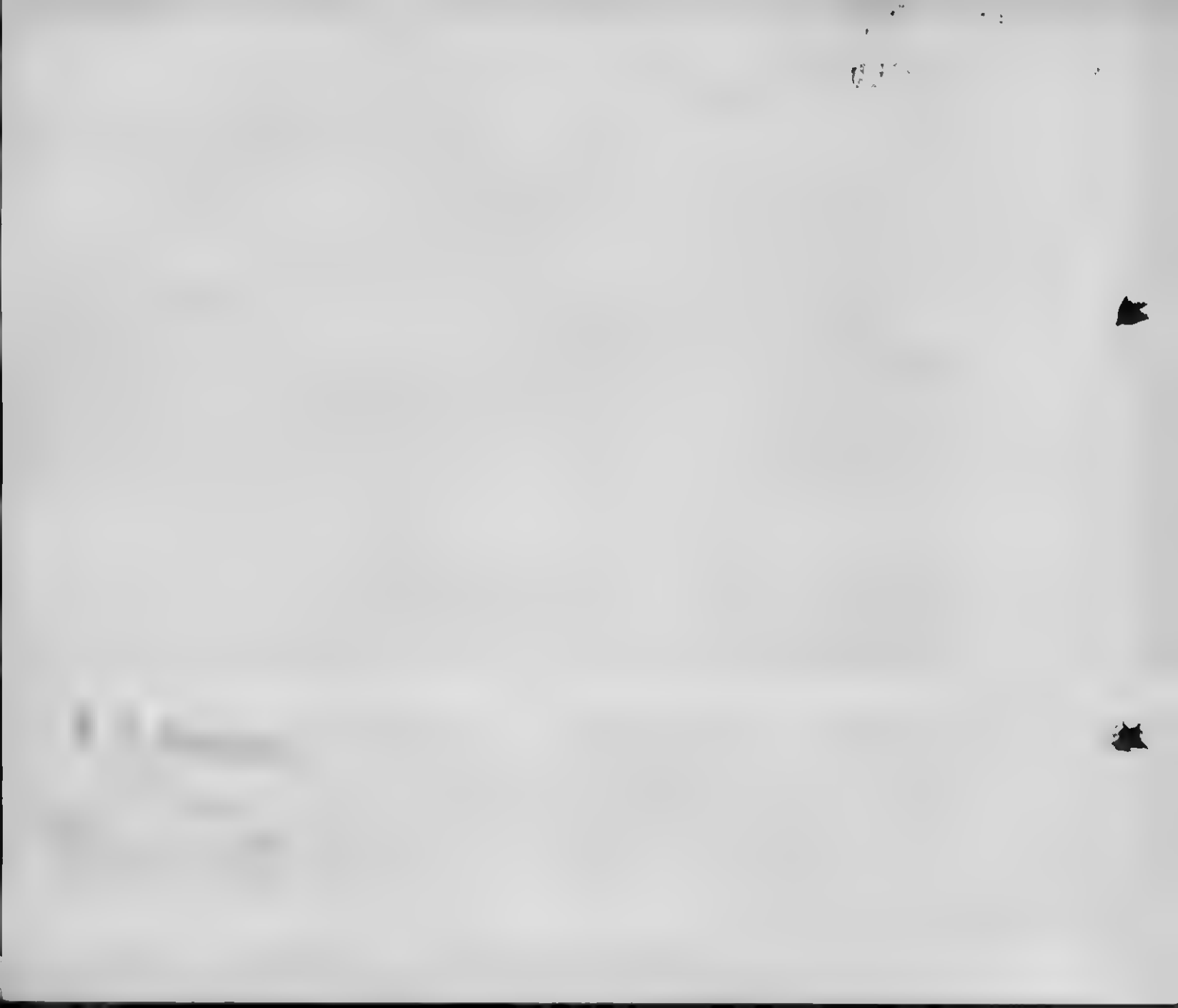
No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN (rural) <u>Cumberland</u>	
TOWN <u>Cumberland</u>		<u>2 days</u>		STREET ADDRESS (If rural, give location)		<u>7. D. 6 Locust Grove</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>							
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Mazie</u>		(Middle) <u>Ellen</u>		(Last) <u>Hendrickson</u>		(Month) (Day) (Year) <u>Sept. 2 1955</u>	
(Type or Print)							
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Feb. 11-1865</u>	9. AGE last birthday: <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Near - Artomas, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Phoebe Cooner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>(son) Paul Hendrickson, Cumberland, Md.</u>			
(If Yes, give war or dates of service)							

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>Immediate cause</u> (a) <u>Uremia due to</u> DUE TO <u>Anuria</u> Complete- <u>2 days</u> <u>Antecedent cause(s)</u> (b) <u>Dehydration</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>stating underlying cause last</u> (c) <u>also was blind (bilateral)</u> <u>15 years</u>					
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Intertrochanteric fracture of left femur.</u>				<u>3 months</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Locust Grove</u>		21c. (City or town) (County) (State) <u>Allegany Id.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 26/55 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>While dressing, legs gave away and she fell to the floor.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER DATE SIGNED			
<u>H.V. Deming M.D.</u>		<u>Sept 2-1955</u>			
DEPUTY MEDICAL EXAMINER		M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>9-4-1955</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. DATE REC'D BY LOCAL REG. <u>Sept. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR ADDRESS <u>Charles L. George - Cumberland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8252

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE W. VA.		COUNTY MINERAL	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		8 DAYS		TOWN RIDGELEY,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		MEMORIAL HOSPITAL MEMORIAL AVE.		STREET ADDRESS (If rural give location)			
10				RT. #1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MR. GEORGE (Middle) Edward (Last) HUTT				(Month) SEPT. (Day) 15 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	DEC. 26, 1900	54 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Electrician		Celanese		XXXXXXXXXX Indiana		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OTIS HUTT				RB RHODA COX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		217-10-5331		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
340.3 IMMEDIATE CAUSE (A) <u>Uraemia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Paralytic Illness</u>						7 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Meningitis</u>						5 days	
						10 days	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1955</u> , to <u>Sept. 15, 1955</u> , that I last saw the deceased alive on <u>Sept. 15, 1955</u> , and that death occurred at <u>8:58 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Clayton L. Swann</u>				DATE SIGNED <u>9/16/55</u>			
M.D. <u>Cumberland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Sept. 18, 1955		Greenmount Cemetery		Cumberland, Md.	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Walter R. Huntz, M.D.</u>		<u>Charles L. George</u>		Cumberland, Md.	

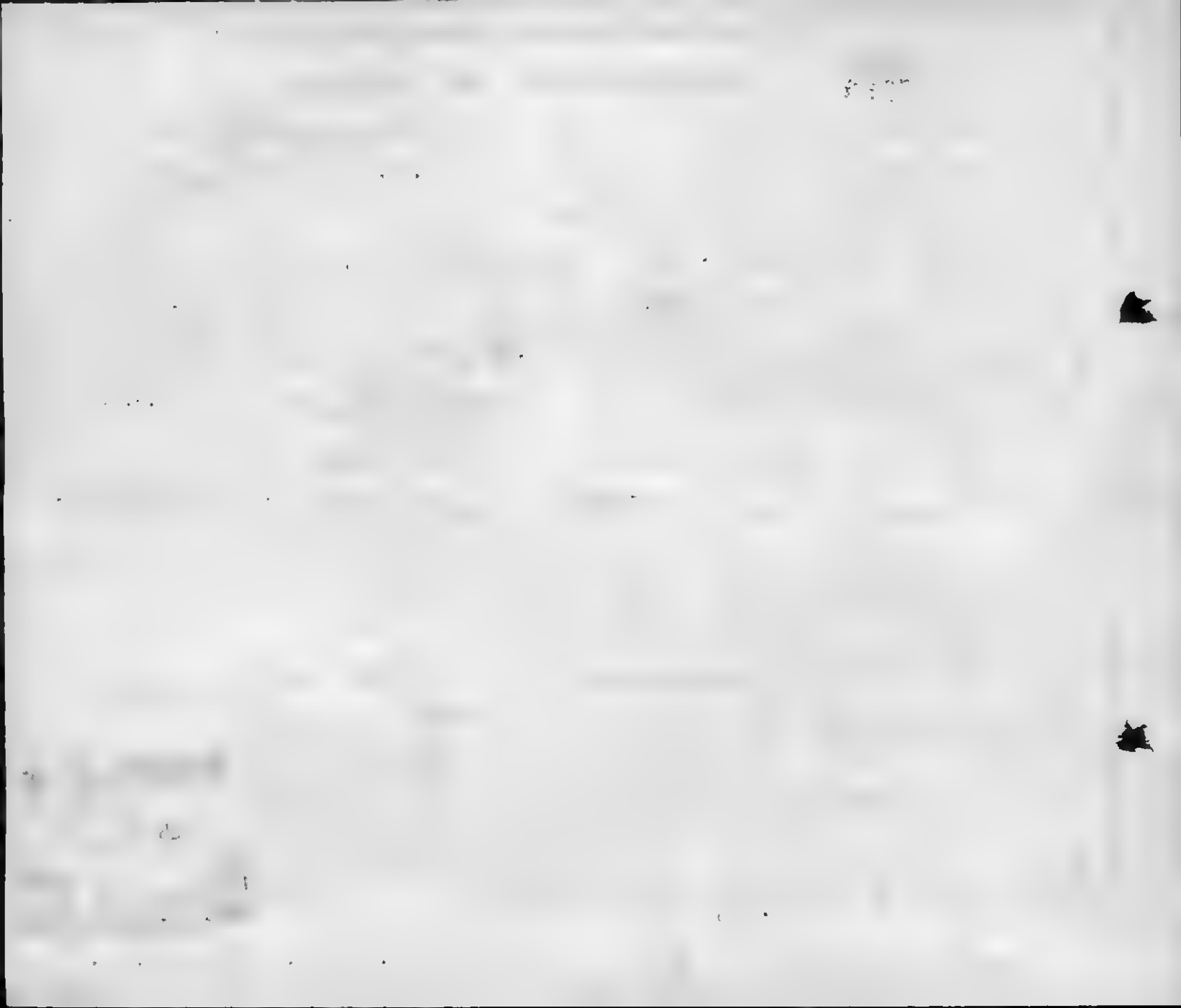
INSTRUCTIONS

1 **WITHIN 24 HOURS** after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M



8253

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>7 Days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>128 Frederick St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Helen</u> (Middle) <u>Ellen</u> (Last) <u>Johnston</u>				(Month) <u>Sept.</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
<u>Female</u>	<u>White</u>	<u>Separated</u>	<u>June 10 1882</u>	<u>73</u> yrs.	Months	Days	Hours Min.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12. CITIZEN OF WHAT COUNTRY?				
<u>Home Nurse</u>			<u>U.S.A.</u>				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Johnston</u>				<u>Rebecca (nydey) Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Sister Mrs Agnes Wilbert Cumberland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				<u>CORONARY OCCLUSION</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Arteriosclerotic heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Recent myocardial infarction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				<u>Generalized arteriosclerosis</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>None</u>		<u>None</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>None</u>		<u>None</u>		<u>None</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>None</u>		<u>None</u>		<u>None</u>			
22. I hereby certify that I attended the deceased from <u>Sept 13, 1955</u> to <u>Sept 20, 1955</u> , that I last saw the deceased alive on <u>Sept 20, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Hallinan MD</u>				ADDRESS (Street, city, town, state) <u>140 Bedford St. Cumberland, Md.</u>			
DATE SIGNED <u>9-21-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 23 1955</u>		<u>Greenway Cemetery</u>		<u>Berkley Spring W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept. 22, 1955</u>		<u>Walter R. Trant, M.D.</u>		<u>W. H. K. K.</u>		<u>Cumberland, Md.</u>	

1 INSTRUCTIONS -

TO ATTENDING PHYSICIAN IN HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-55 10M



08270

8284

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>Life time</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>61 Miner's Hospital</u>				<u>6 Grant Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Carrie M. Keilling</u>				<u>9 20 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>4-8-1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own Home</u>		<u>Zihlman, Md.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel H. Harden</u>				<u>Josephine Moser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>160 Mt. Pleasant St</u> <u>Mrs. James V. Miller, Daughter</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
20. IMMEDIATE CAUSE (A)				<u>Cerebral Vascular Accident</u>			
21. ANTECEDENT CAUSE(S) DUE TO				<u>Atherosclerosis</u>			
22. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Diabetes Mellitus</u>			
23. STATING UNDERLYING CAUSE LAST							
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/53</u> to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>55</u> , and that death occurred at <u>5:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>John C. Oliver</u>				<u>Frostburg Md.</u>		<u>9/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-22-1955</u>		<u>Frostburg Memorial</u>		<u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>9-23-55</u>		<u>Mrs. Nancy N. Roe</u>		<u>Pearl H. Reptinghly</u>		<u>Frostburg Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M



8293

08271

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Allegheny</u>	MARYLAND		STATE <u>Md.</u>	COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Rural) Rawlings</u>	LENGTH OF STAY (in this place) <u>27 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Rural) Rawlings (Black Oak Farm)</u>	<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Potomac River, half way between Rawlings & Dawson, Md.</u>			STREET ADDRESS (If rural, give location) <u>7.F.D.#3 Keyser, W. Va.</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) <u>Raymond</u>	(Middle) <u>Forest</u>	(Last) <u>Kile</u>	Date of Death <u>Sept. 18 19 55</u>		
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>July 29-1928</u>		
9. AGE last birthday: <u>27</u> yrs.			10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Tractor driver</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>B&O R.R.</u>		
11. BIRTHPLACE (State or foreign country): <u>Black Oak Farm, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Loy T. Kile</u>			14. MOTHER'S MAIDEN NAME: <u>Mary Hazel Kimble</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Korea</u>			16. SOCIAL SECURITY No.: <u>234-44-6741</u>		
17. INFORMANT & ADDRESS: <u>7.F.D. 3 Keyser, W. Va.</u>			18. (father) <u>Loy T. Kile, Black Oak Farm, Md.</u>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>429.8</u> Immediate cause (a) <u>Asphyxia</u> DUE TO <u>accidental drowning</u>			<u>sudden</u>		
Antecedent cause(s) (b) <u> </u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u> </u> stating underlying cause last (c) <u> </u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:			19b. MAJOR FINDING OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY <u>Potomac River</u>		21c. (City or town) (County) (State) <u>Near) Rawlings Allegheny Md.</u>	
21d. TIME (Month) (Day) (Year) <u>Sept. 18-1955 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Drown while trying to save another person.</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>H.V. Dering M.D.</u> <u>H.V. Dering M.D.</u> M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <u>Sept. 19-1955</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Dawson, Cemetery</u>	
LOCATION (City, town, or county) <u>Dawson, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Rogers Funeral Home, Keyser, W. Va.</u>			
DATE REC'D BY LOCAL REG. <u>Sept 22, 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs Jean C. Kelly</u>		25. FUNERAL DIRECTOR ADDRESS <u>Rogers Funeral Home, Keyser, W. Va.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

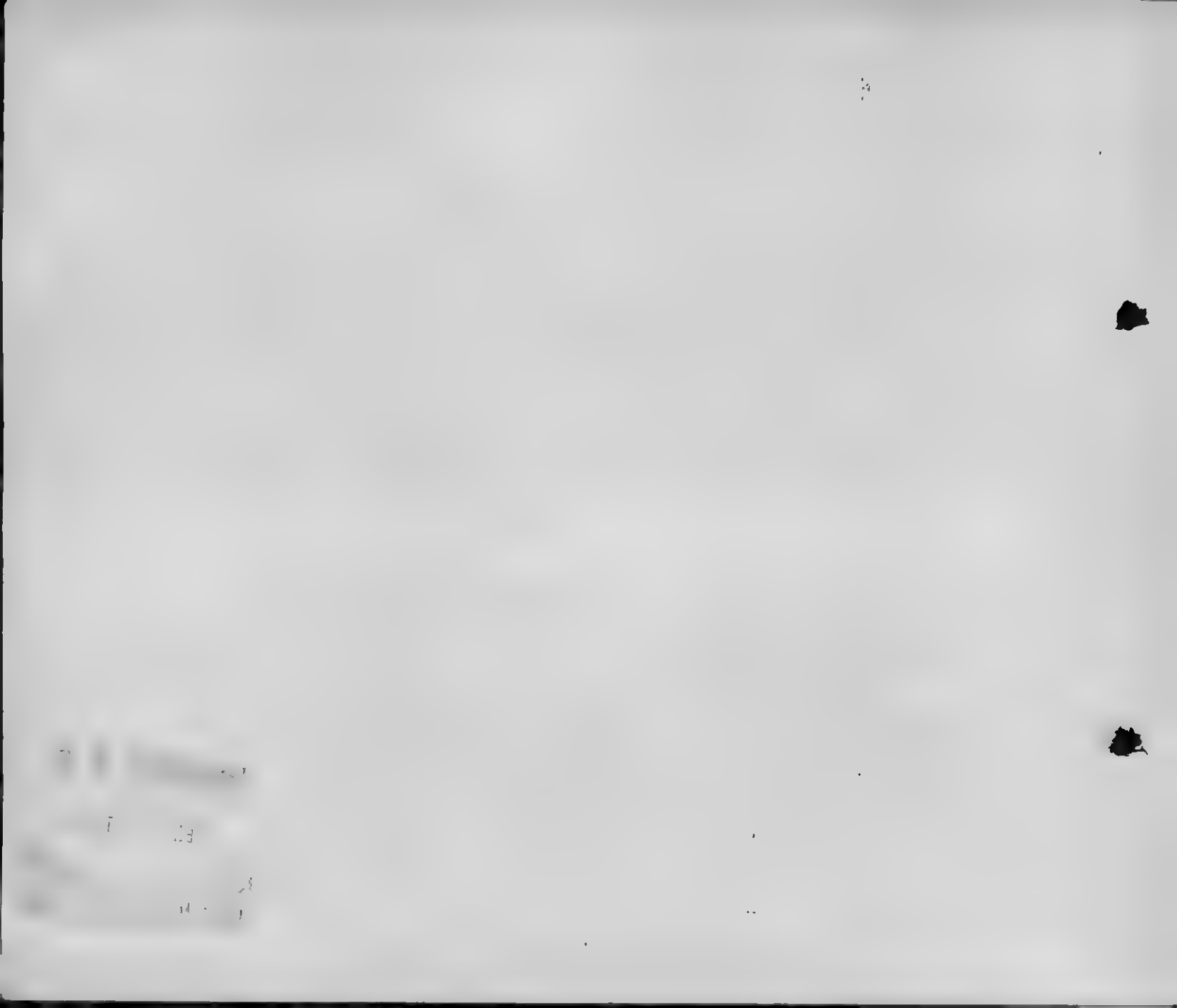
8285

08272

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 9

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Pa.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Frostburg</u>	LENGTH OF STAY (in this place) <u>14 hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Frostburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>		STREET ADDRESS (If rural, give location) <u>Spring St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Emma</u>		4. DATE OF DEATH <u>Sept. 14</u> 19 <u>55</u>	
(First) (Middle) (Last)			
<u>Lancaster</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 5-1881</u>
9. AGE last birthday: <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Rawlings, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Levi Robinson</u>		14. MOTHER'S MAIDEN NAME: <u>Amanda Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	17. INFORMANT & ADDRESS: <u>(daughter) Cora Tarrat, Frostburg, Md.</u>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Myocardial infarction</u>			<u>about 1 hour.</u>
DUE TO			
Antecedent cause(s) (b) <u>Coronary occlusion</u>			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c) <u>also had Cardiac hypertrophy.</u>			<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>			
SIGNATURE <u>H. V. Deming M.D.</u>		M. D. <u>H. V. Deming M.D.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9-16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
DATE REC'D BY LOCAL REG. <u>9-16-55</u>		REGISTERAR'S SIGNATURE <u>Mrs. Nancy N. Roe</u>	
24. FUNERAL DIRECTOR <u>Charles H. Mattingly, Frostburg, Md.</u>		ADDRESS	



1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been recorded by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

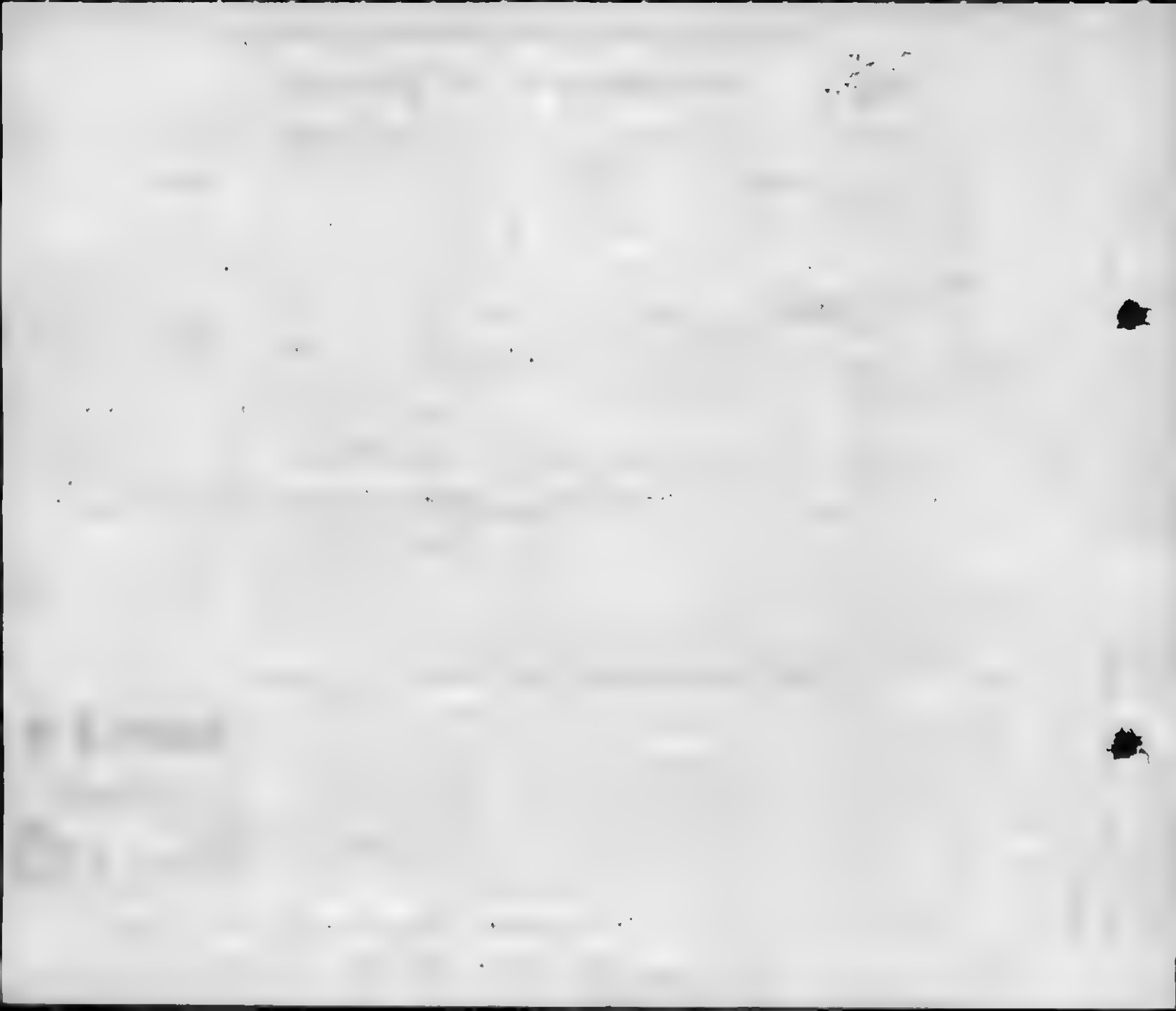
8254

CERTIFICATE OF DEATH

08273

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>4 days</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>311 Avirett Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Margaret</u> (Last) <u>Lowery</u>				(Month) <u>9</u> (Day) <u>1</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 3, 1837</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housework</u>		<u>Maryland Cumberland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Hoffman</u>				<u>Mary Felkner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>218-30-0591 A</u>		<u>Cumberland, Md.</u> <u>Mrs. David McMillan 311 Avirett Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>12 mos</u>	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Atherosclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15, 1954</u> , to <u>Sept 26, 1955</u> , that I last saw the deceased alive on <u>Sept 26, 1955</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Rosa W. Baer</u>				<u>M.D. 62 Greene St., Cumberland, Md.</u>		<u>9-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>9/29/55</u>	<u>St. Luke's Cem.</u>		<u>Cumberland, Maryland</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				
<u>Sept. 28, 1955</u>	<u>Walter R. Jantz, M.D.</u>		<u>H. Wayne George</u> <u>Cumberland, Md.</u>				



1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08275

8255

CERTIFICATE OF DEATH

Item 12, File GL86 9-20-55 et

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
C2 TOWN CUMBERLAND				OR TOWN LONACONING		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 SACRED HEART HOSPITAL				WATERCLIFF ST., BOX 382			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
ANDREW MCDONALD				9-13-55 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
MALE	WHITE	SINGLE	10-28-77	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
1100 LINE WORKER					SCOTLAND		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John McDonald				MARGARET Carlaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
NO				216-07-2799		CHART	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4:00 PM IMMEDIATE CAUSE (A)				Coronary Occlusion			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
0						2d	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1955, to 9/13, 1955, that I last saw the deceased alive on 9/13, 1955, and that death occurred at 8:00 AM, from the causes and on the date stated above.							
SIGNATURE George Richardson, M.D.				ADDRESS (Street, city, town, state) Lonaconing, Md.		DATE SIGNED 9-13-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 15, 1955		Oak Hill Cemetery		Lonaconing, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 14, 1955		Walter K. Frantz, M.D.		GEORGE EICHORN, Lonaconing, MD			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3 A 011000

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11 11 11

1 **Outside of City Limits**

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08276

8294

CERTIFICATE OF DEATH

Reg. Dist. No. 4

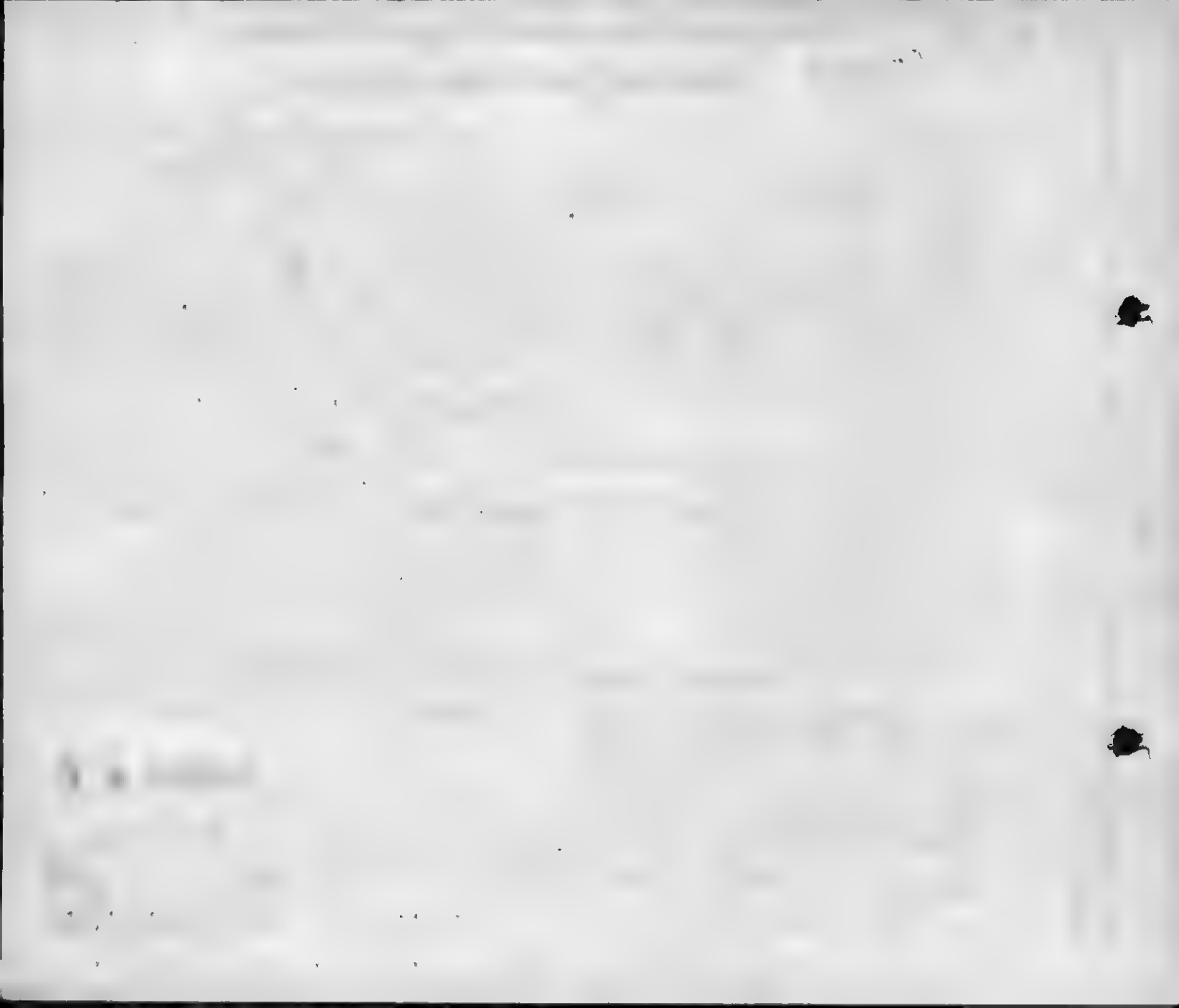
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cresaptown</u>		<u>9 yrs.</u>		TOWN <u>Cresaptown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10				1			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>ROBERT ARTHUR MC INTOSH</u>				<u>Sept. 29, 1955</u>			
5 SEX	6 COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>June 30, 1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>General Farming</u>		<u>Woodstock, Virginia.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Mc Intosh</u>				<u>Mary Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Sadie McKenzie, Cresaptown, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
4200 IMMEDIATE CAUSE (A) <u>congenital heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>transverse myelitis for 40 years</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-4</u> , 19 <u>55</u> , to <u>9-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-29</u> , 19 <u>55</u> , and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>W. H. Hines</u>				ADDRESS (Street, city, town, state) <u>57 Green St. Cumberland Md 210-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1955</u>		<u>Burlington, W. Va., Cem</u>		<u>Burlington, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Oct. 1, 1955</u>		<u>Winter R. Frank, M.D.</u>		<u>John J. Hafer, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS AISC 1-55 10M



8256

CERTIFICATE OF DEATH

Reg. Dist. No. 4

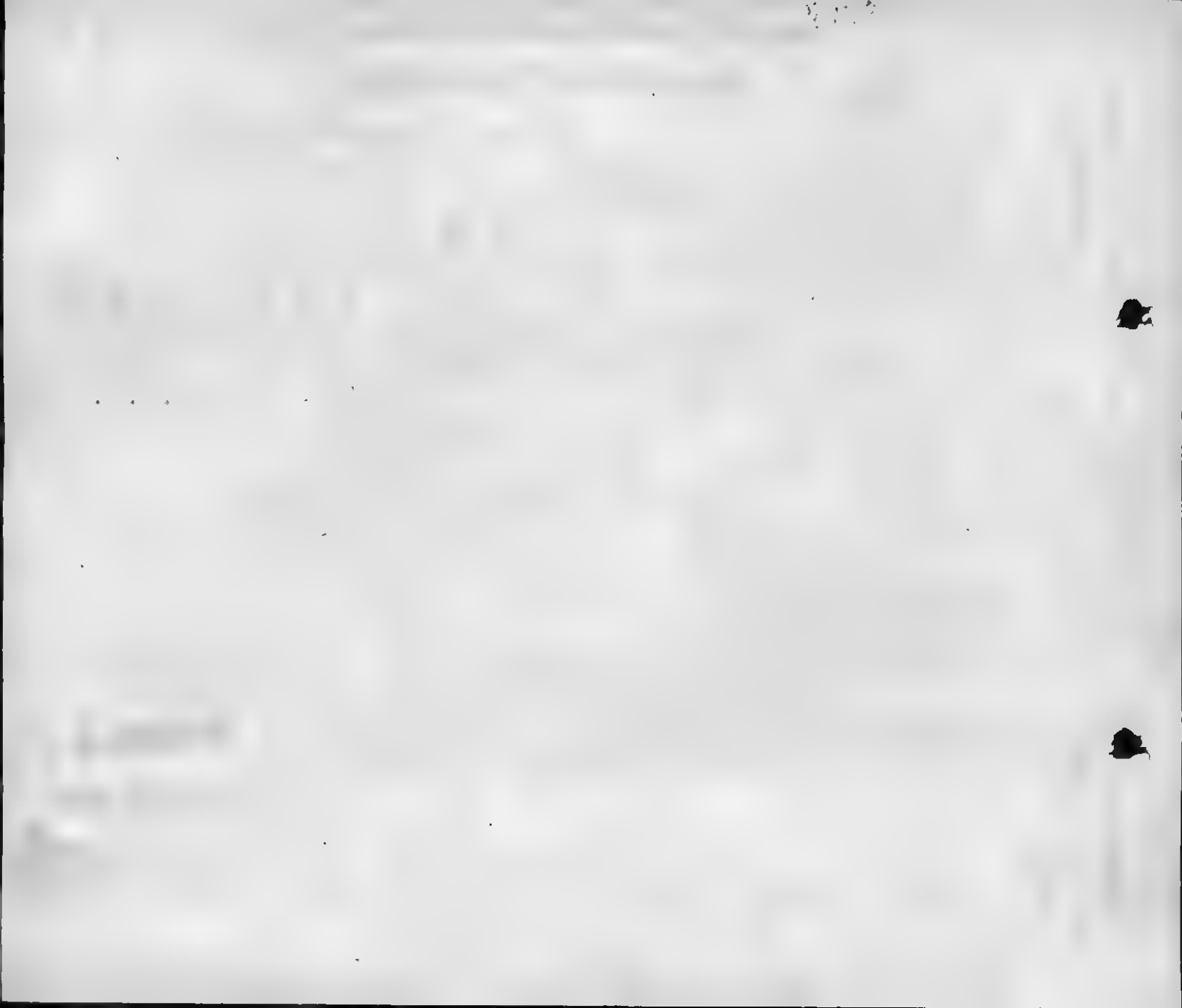
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY OR TOWN CUMBERLAND, MARYLAND		LENGTH OF STAY (in this place) 82 DAYS		CITY OR TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 7 CRESAP STREET			
3. NAME OF DECEASED (First) (Middle) (Last) BEULAH MILLER				4. DATE OF DEATH (Month) (Day) (Year) 9 20 19 55			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JUNE 17, 1891	9. AGE last birthday 64 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA, Hampshire Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A. USA	
13. FATHER'S NAME DAVID BEAN				14. MOTHER'S MAIDEN NAME GERTRUDE SINDY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL, MEMORIAL AVENUE			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) Carcinomatosis							
ANTECEDENT CAUSE(S) DUE TO Carcinoma breast							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 11/22/54		19b. MAJOR FINDINGS OF OPERATION Carcinoma breast		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 30, 1955, to Sept. 20, 1955, that I last saw the deceased alive on Sept. 9, 1955, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 9-23-55		NAME OF CEMETERY OR CREMATORY Indian Mount Cem	
				LOCATION (City, town, or county) Romney, W. Va.		(State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 23, 1955		Winter R. Frantz, M.D.		James F. Scarpelli		Cumberland, Md	

INSTRUCTIONS

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2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

I. PLACE OF DEATH:

COUNTY Allegheny MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Cumberland LENGTH OF STAY (in this place) 7 yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegheny County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Id. COUNTY Allegheny
 CITY (If outside corporate limits write RURAL and give nearest town)
 OR TOWN Westernport, 43
 STREET ADDRESS (If rural, give location) 1

3. NAME OF DECEASED:

(First) (Middle) (Last)
Charles Robert Miller

4. DATE OF DEATH (Month) (Day) (Year)
Sept. 27 19 55

5. SEX:

6. COLOR OR RACE:
male white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1879

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)
Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY:
Mining coal

11. BIRTHPLACE (State or foreign country):
Westernport, Id.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

John Miller

14. MOTHER'S MAIDEN NAME:

Mary Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
no

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS:

Allegheny Co. Infirmary records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

900.7
 Immediate cause (a) Intracranial hemorrhage

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

(b) a fractured skull.

INTERVAL BETWEEN ONSET AND DEATH
16 hrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

Concrete walk.

20. AUTOPSY?
 Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐

21b. PLACE (Home, farm, factory, etc.) OF INJURY street, Cumberland

21c. (City or town) (County) (State)
Cumberland Allegheny Id.

21d. TIME (Month) (Day) (Year) 3 (Hour) Sept. 26-7

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? stepping out side steps, mis-step, fell backward hit head on concrete wall

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

H.V. Deming M.D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Sept. 27/55
 DEPUTY MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF Sept. 29, 1955

NAME OF CEMETERY OR CREMATORY Westport Cemetery

LOCATION (City, town, or county) (State)
Westernport, Maryland

DATE REC'D BY LOCAL REG. Sept. 28, 1955

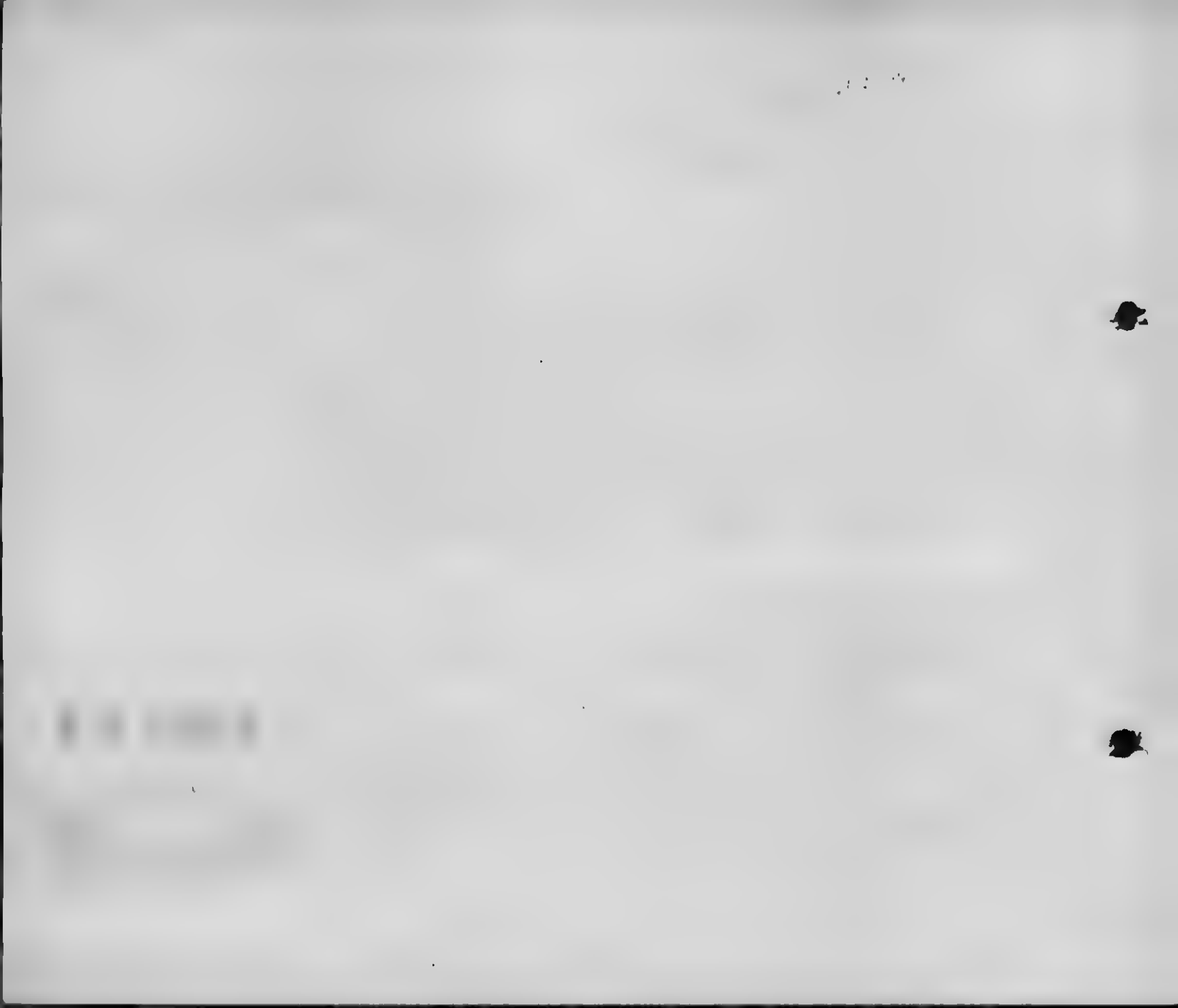
REGISTRAR'S SIGNATURE Walter K. Brant, M.D.

24. FUNERAL DIRECTOR Boada

ADDRESS Boada

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08279

8258

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Allegany		STATE		Maryland	
CITY OR TOWN		Cumberland		COUNTY		Allegany	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		47 Marion Street		STREET ADDRESS		47 Marion Street	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
MALINDA JANE MORSE				Sept. 20 1955			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
female		white		Married		Apr. 4, 1982	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
73 yrs.		Houseworker		Allegany County, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MARDEN NAME			
Austin Hartsock				Nancy Robinette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		218-30-0762		John A. Morse, Cumberland, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4 mo.			
441x IMMEDIATE CAUSE (A) Cerebral Hemorrhage multiple				4 mo.			
ANTECEDENT CAUSE(S) DUE TO Hypertensive Heart Disease				20 yr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO Generalized Arteriosclerosis				20 yr.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
none				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
none		none		none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
none		M.		none			
22. I hereby certify that I attended the deceased from 5-5-1954 to Sept. 20, 1955, that I last saw the deceased alive on Sept. 20, 1955, and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
J. H. Haefer		Sept. 22, 1955		Fairview Christian Cem.		Artemas, Pennsylvania	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Burial		Winter L. Bantz, M.D.		John J. Haefer		Cumberland, Md.	

INSTRUCTIONS

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VS 1157-45 10M



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

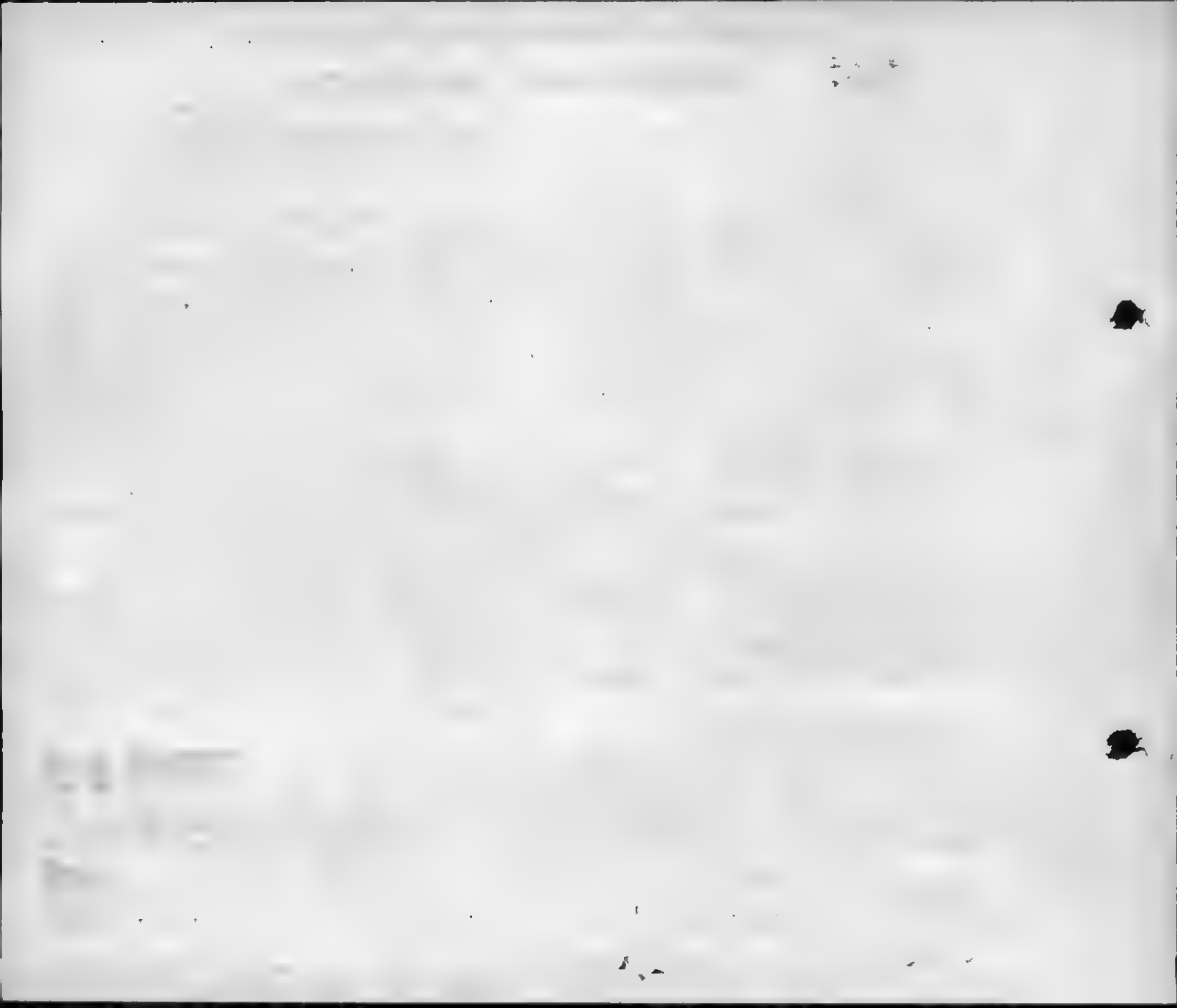
08280

8286

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>				TOWN <u>Frostburg</u>		22	
61 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS (If rural give location) <u>60 Mechanic Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>AGNES (WALKER) MUIR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 20, 1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 8, 1883</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Walker</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Speir</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>James Muir, Frostburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331x IMMEDIATE CAUSE (A) <u>Cerebral Vas. Accident</u>						<u>48 HRS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Fibrosis & Emphysema</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Congestive Heart Failure</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>05</u> , to <u>9/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>John C. [Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Frostburg</u>			
DATE <u>9-22-55</u>				DATE SIGNED <u>9/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-23-1955</u>		NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. REC'D BY REGISTRAR <u>J. R. Durst</u>		REGISTRAR'S SIGNATURE <u>J. R. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>			
DATE <u>9-22-55</u>		REGISTRAR'S SIGNATURE <u>J. R. Durst</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>			



1

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

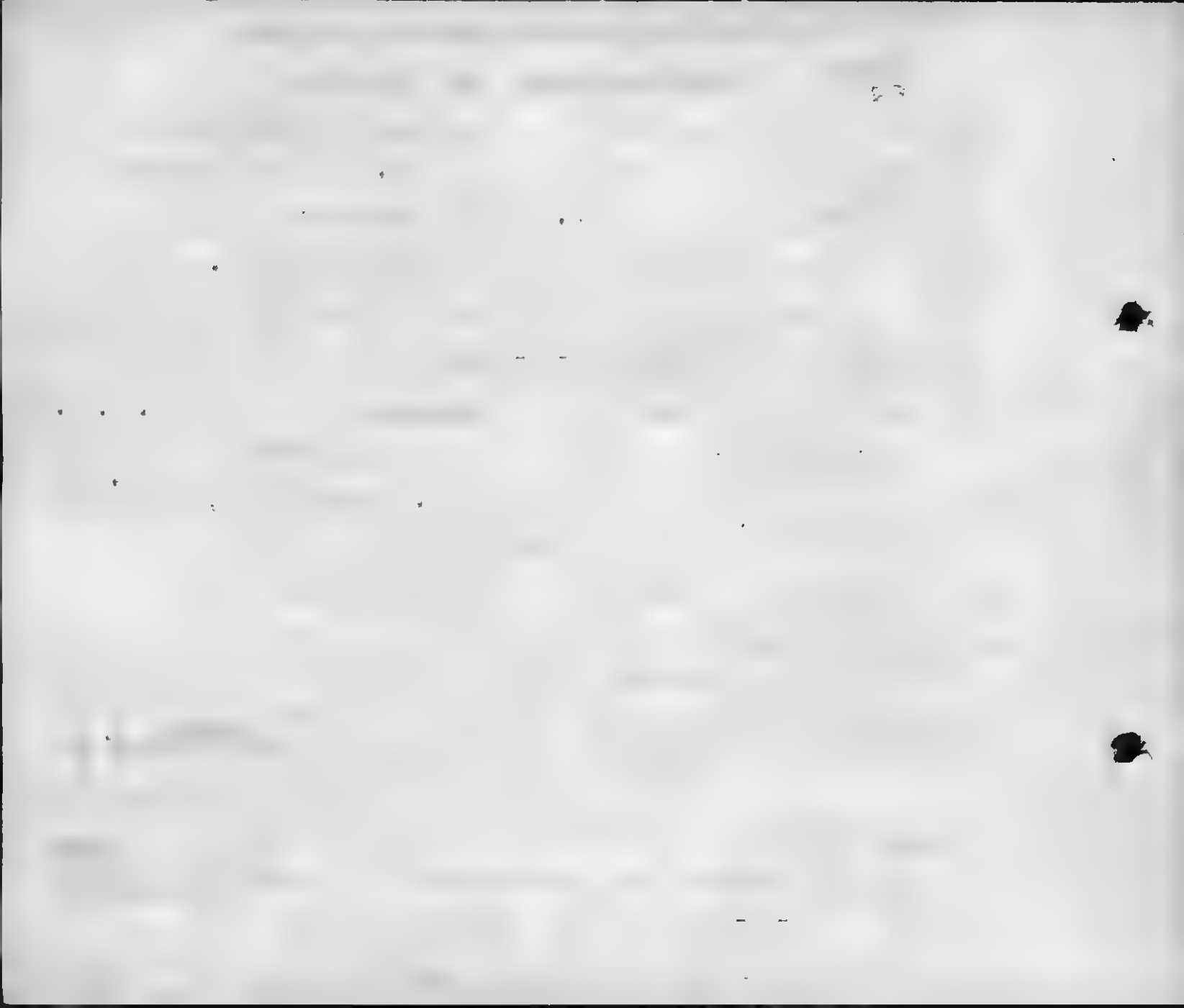
08281

8287

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
22 TOWN <u>Frostburg</u>		5 Mos.		Frostburg		22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
61 <u>Miners Hospital</u>				201 Center St.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Robert Muir</u>				<u>9 21 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	4-28-1885	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Minor		Coal		Mesacon		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S M maiden NAME			
<u>Michael Muir</u>				<u>Tilford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>201 Center St. City</u>			
				<u>Mr. Clarence Muir, Son</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
525x IMMEDIATE CAUSE (A) <u>Pulmonary Fibrosis + Emphysema</u>						10 YRS	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1</u> , 19 <u>55</u> , to <u>Sept</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>55</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John C. Devers</u>				ADDRESS (Street, city, town, state) <u>Frostburg Md</u>		DATE SIGNED <u>9/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-23-55		Frostburg Memorial		Frostburg Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>9-23-55</u>		<u>Mr. Nancy M. Rice</u>		<u>Pearl H. Montague</u>		<u>Frostburg Md</u>	



1

INSTRUCTIONS

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VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8295

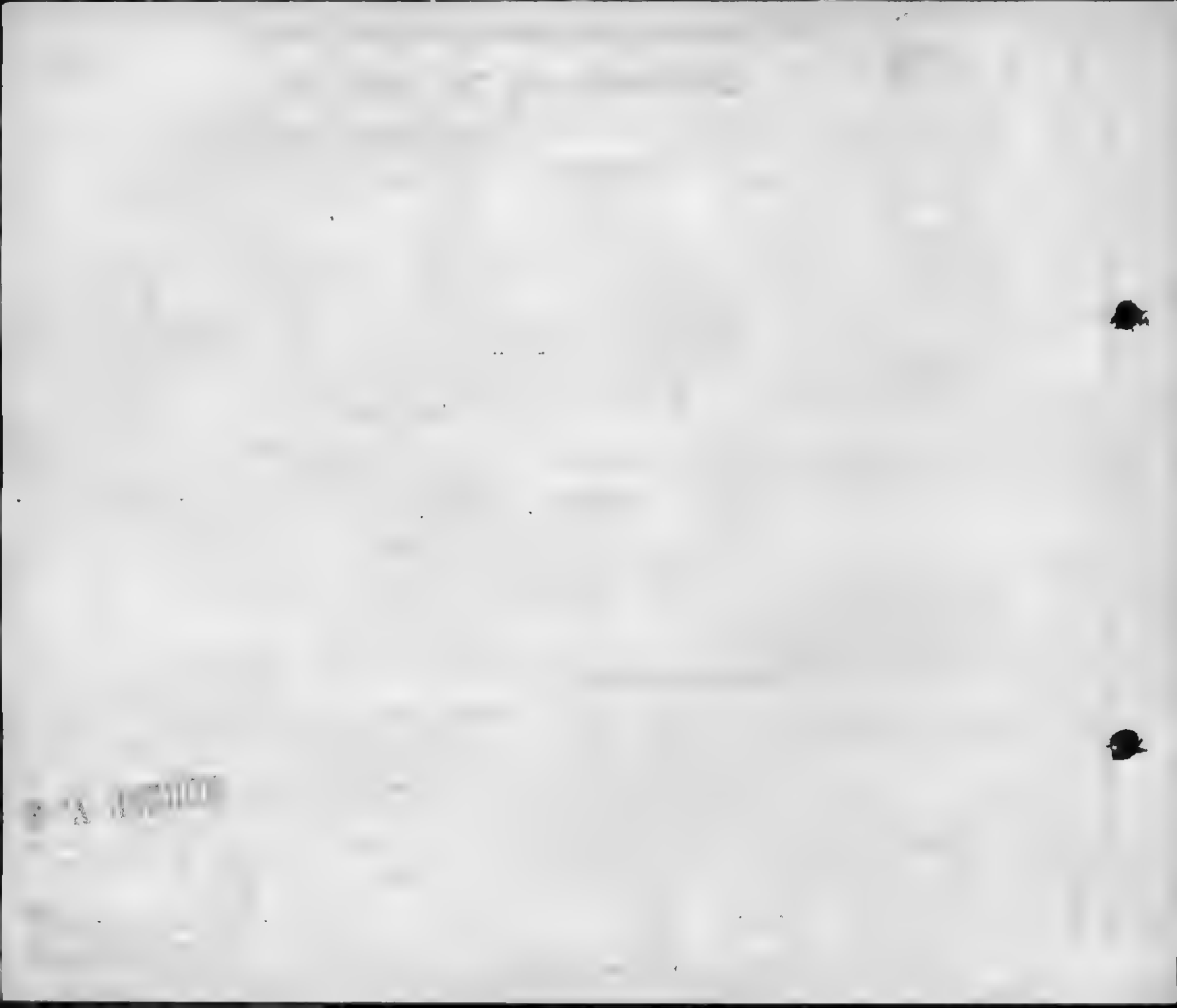
CERTIFICATE OF DEATH

08282

Item 9, Film G186 9-19-55 et

Reg. Dist. No. 10

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>					
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Savage,</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CO</u>		STREET ADDRESS (If rural give location) <u>Railroad Street</u>					
3. NAME OF DECEASED (First) (Middle) (Last) <u>Cecilia Mary Mullaney</u>							
4. DATE OF DEATH (Month) (Day) (Year) <u>9 - 11 19 55</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>11-24-1864</u>				
9. AGE last birthday <u>90 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>					
11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Martin Carabine</u>		14. MOTHER'S MAIDEN NAME <u>Catherine McQuade</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT & ADDRESS <u>Chas. F. Mullaney, Mt. Savage, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (A) <u>Acute Heart Failure</u>			<u>4 days</u>				
ANTECEDENT CAUSE(S) DUE TO (B) <u>Serious</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)					
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Sept 8, 1955</u>, to <u>Sept 11, 1955</u>, that I last saw the deceased alive on <u>Sept 8, 1955</u>, and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. R. Durst</u> M.D.		DATE SIGNED <u>Sept 13, 1955</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-14-1955</u>					
NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Savage, Md.</u>					
24. REC'D BY REGISTRAR <u>Veronica M. Dermott</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>					
DATE <u>9-13-1955</u>		ADDRESS <u>Frostburg, Md.</u>					



1
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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

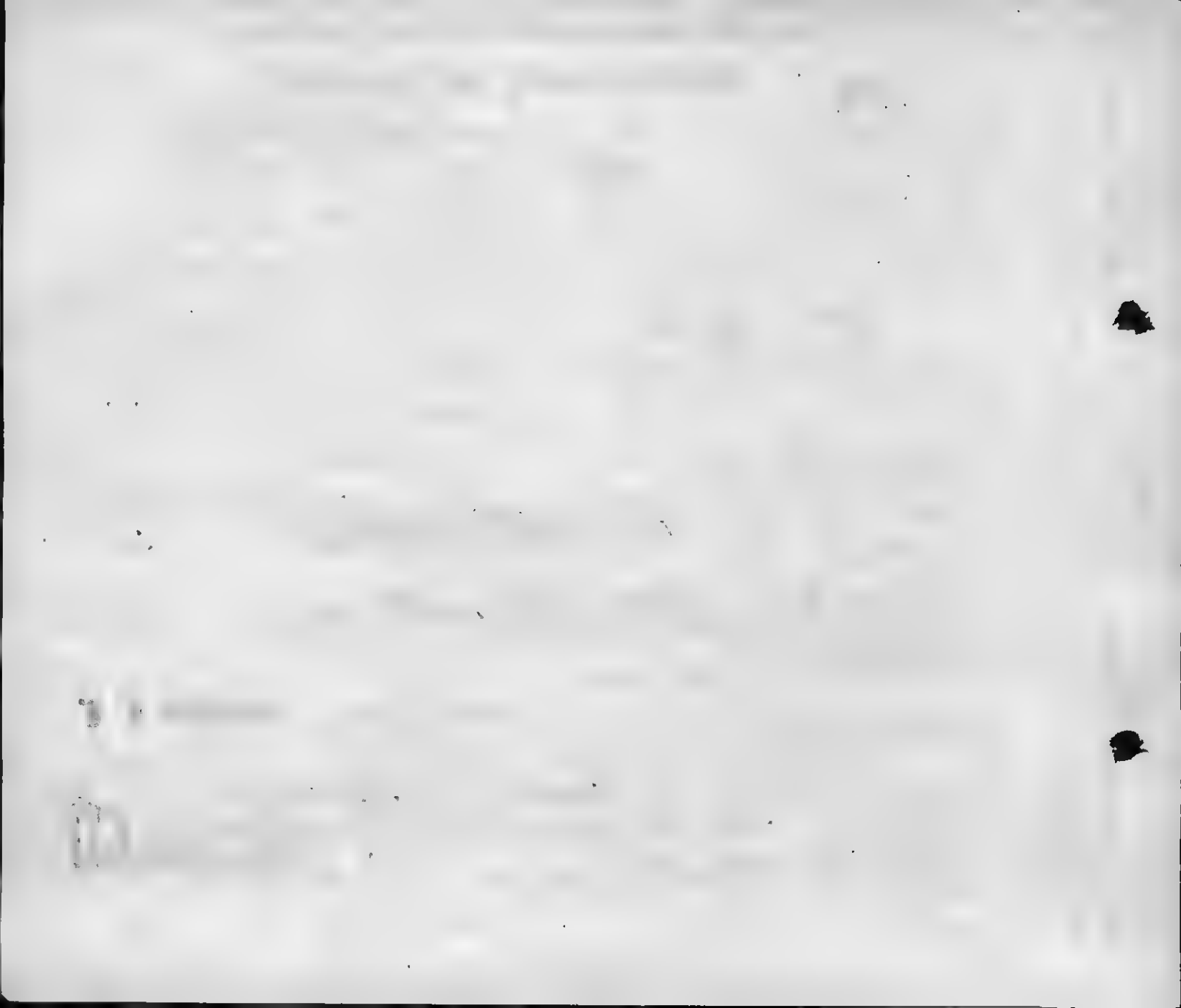
8259

CERTIFICATE OF DEATH

08283

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 TOWN Cumberland</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>320 Waverly Terrace</u>				STREET ADDRESS (If rural give location) <u>320 Waverly Terrace</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARTHA JANE NEWELL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 17 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 5, 1871</u>		9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Twiggstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE RICE</u>				14. MOTHER'S MAIDEN NAME <u>RACHAEL WILLISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. J. W. Wagner, Cumberland, Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>331x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) <u>Arterial Hypertension</u>						<u>2 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 12</u> , 19 <u>55</u> , to <u>Sept 17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept 17</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above. <u>9/19/55</u>							
SIGNATURE <u>R. W. Drach, Jr.</u>				ADDRESS (Street, city, town, state) <u>Cumberland, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Hantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer,</u>		ADDRESS <u>Cumberland, Maryland</u>	



1
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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

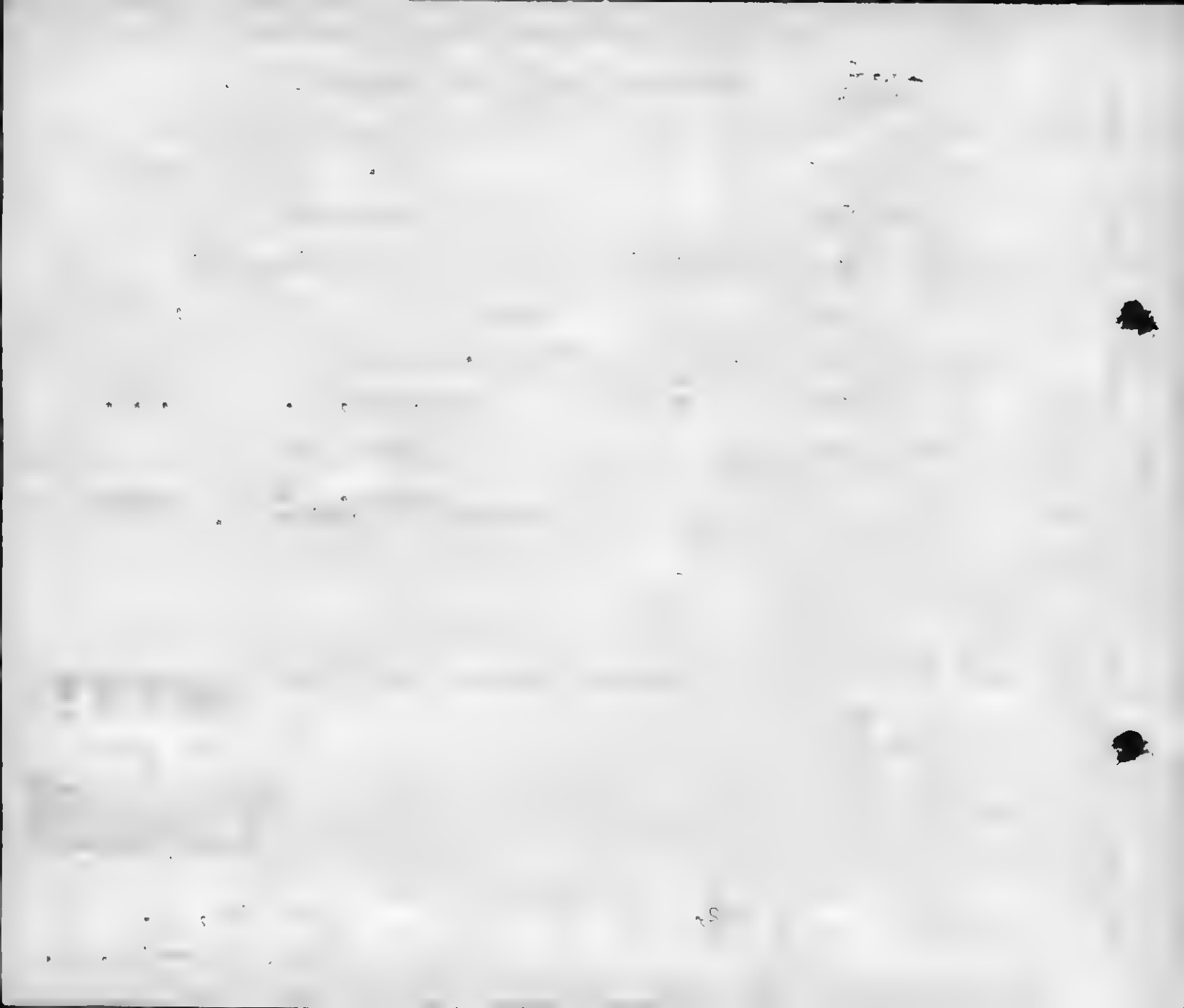
08284

CERTIFICATE OF DEATH

Reg. Dist. No. 4

8260

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE MD.		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland				TOWN Lonaconing			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Sacred Heart Hospital				East Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JESSIE (Middle) NICHOLS (Last)				(Month) Sept. (Day) 16th (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Female	White	Married	May, 10th, 1878	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housework		Own Home		Lonaconing, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Heron				Jean Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
4 No (If Yes, give war or dates of service)		None		Lindley P. Nichols (Husband)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434X IMMEDIATE CAUSE (A) Massive Pulmonary Emboli				Lonaconing, MD.		2d.	
ANTECEDENT CAUSE(S) DUE TO (B) Thrombophlebitis						4 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) congestive heart failure						7 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1957 to 16 Sept. 1955 , that I last saw the deceased alive on 16 Sept. 1955 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE George R. Eichhorn				ADDRESS (Street, city, town, state) Lonaconing, Md.		DATE SIGNED 9-17-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 22, 1955		Oak Hill Cemetery		Lonaconing, MD.	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept 21, 1955		Winter R. Frantz, M.D.		George Eichhorn, Lonaconing, MD.			



8261

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		9 HRS. 15 MIN.		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				231 ARCH STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) FRANK (Middle) H (Last) PADFIELD				(Month) (Day) (Year) SEPTEMBER 14, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	MARRIED	NOV. 25, 1890	64 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer - L. Bernstein Furniture Company					PENNSYLVANIA		U.S.A
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN PADFIELD				MARY ALDOM			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		214-07-0519		Memorial Hospital, Cumberland, Maryland.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
1X IMMEDIATE CAUSE (A)				Massive Cerebral Haemorrhage			
ANTECEDENT CAUSE(S) DUE TO (B)				Left Hemiplegia			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Hypertension			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 14, 1955, to Sept. 14, 1955, that I last saw the deceased alive on Sept. 14, 1955, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Clayton J. Lueret M.D. Cumberland						9/15/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 17, 1955		Rose Hill Cemetery		Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 17, 1955		Walter R. Trantz M.D.		James F. Scarpelli		Cumberland, Md.	

INSTRUCTIONS

I

15 ATTEND/PHYSICIAN OR HOSPITAL

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

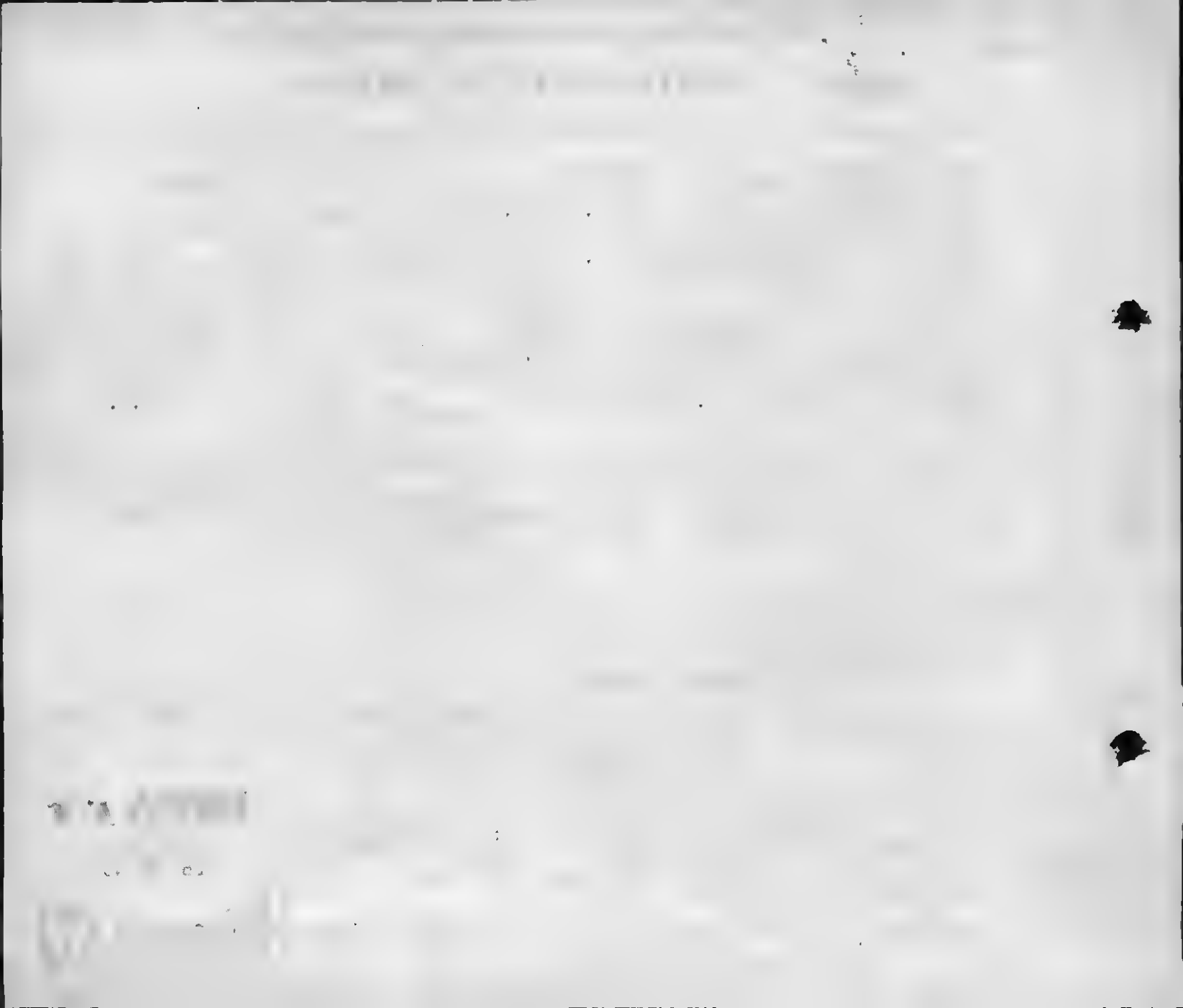
1 WITHIN CORPORATE LIMITS

The law requires that the death certificate be executed within 24 hours after death.

After this

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this

death certificate assembly should be detached for use as a burial transit permit.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8288

CERTIFICATE OF DEATH

08286

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Frostburg		life		TOWN Frostburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Bowery St.				STREET ADDRESS (If rural give location) 19 Bowery St.			
3. NAME OF DECEASED (Type or Print) MARY M. PHILLIPS				4. DATE OF DEATH (Month) (Day) (Year) Sept. 8, 19 55			
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 5-26-1880		9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. D. Morgan				14. MOTHER'S MAIDEN NAME Mary Ann Wilcox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Eli Phillips, Frostburg, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) myocardial insufficiency						INTERVAL BETWEEN ONSET AND DEATH 2 mo	
ANTECEDENT CAUSE(S) DUE TO (B) hypertension						5 mo	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Cerebral Hemorrhage						2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7:00 P.M., 1953, to 2:00 P.M., 1955, that I last saw the deceased alive on 1-17-53, 1953, and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
SIGNATURE Wm. M. Pare				ADDRESS (Street, city, town, state) Frostburg Md			
DATE SIGNED Sept 9 1955				DATE SIGNED Sept 9 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9-11-1955		NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		LOCATION (City, town, or county) Frostburg, Md.	
24. REC'D BY REGISTRAR 9-11-55		REGISTRAR'S SIGNATURE Mrs. Nancy H. R...		25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.	

1940

1940

1 **INSTRUCTIONS** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8262

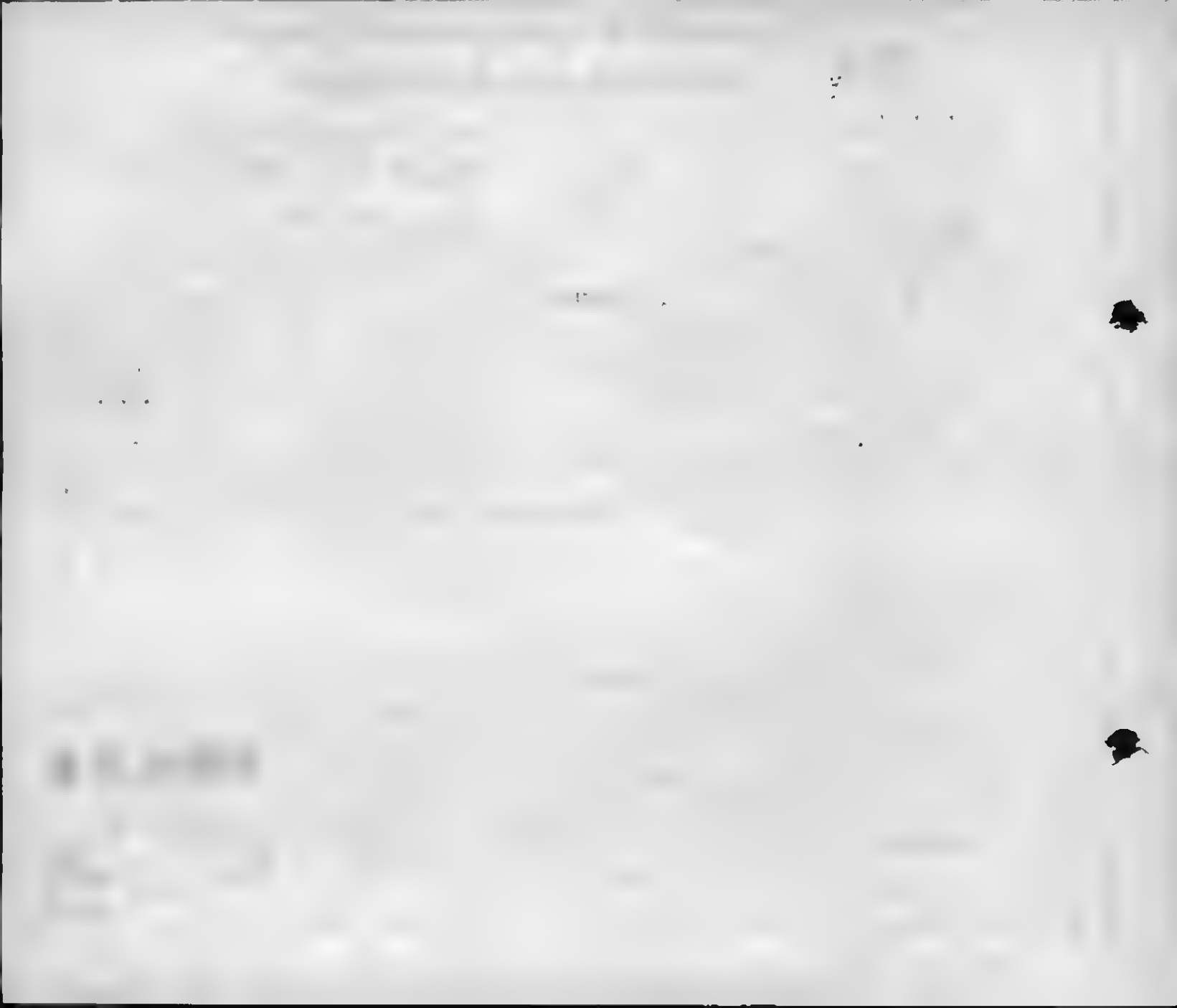
08287

CERTIFICATE OF DEATH

DR. W. F. WILLIAMS

Reg. Dist. No. **4**

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		19 DAYS		TOWN CRESAPTOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS (If rural give location) 439 McMullon Highway			
3. NAME OF DECEASED (First) RAHAH (Middle) ELIZABETH (Last) POWELL				4. DATE OF DEATH (Month) SEPTEMBER (Day) 9 (Year) 1955			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JANUARY 9, 1895	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NELSON M. KELLY				14. MOTHER'S MAIDEN NAME Elizabeth Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL - CUMBERLAND, MD.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Thyrototoxicosis severe						INTERVAL BETWEEN ONSET AND DEATH Approx 3 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Pneumonia, bronchial, bilateral						4 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Nephritis chronic with uremia						4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION Sep 2, 1955		19b. MAJOR FINDINGS OF OPERATION Exoc adenomata thyroid gland				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 20, 1955, to Sep 9, 1955, that I last saw the deceased alive on Sep 8, 1955, and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
SIGNATURE W. M. Fawcett		M.D. Cumberland Md		ADDRESS (Street, city, town, state)		DATE SIGNED Sep 9 '55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 11, 1955		NAME OF CEMETERY OR CREMATORY Powell Family Cemetery		LOCATION (City, town, or county) (State) near Augusta, West Virginia	
24. REC'D BY REGISTRAR Sep 19, 1955		REGISTRAR'S SIGNATURE Walter R. Hantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home - Keeser		ADDRESS	



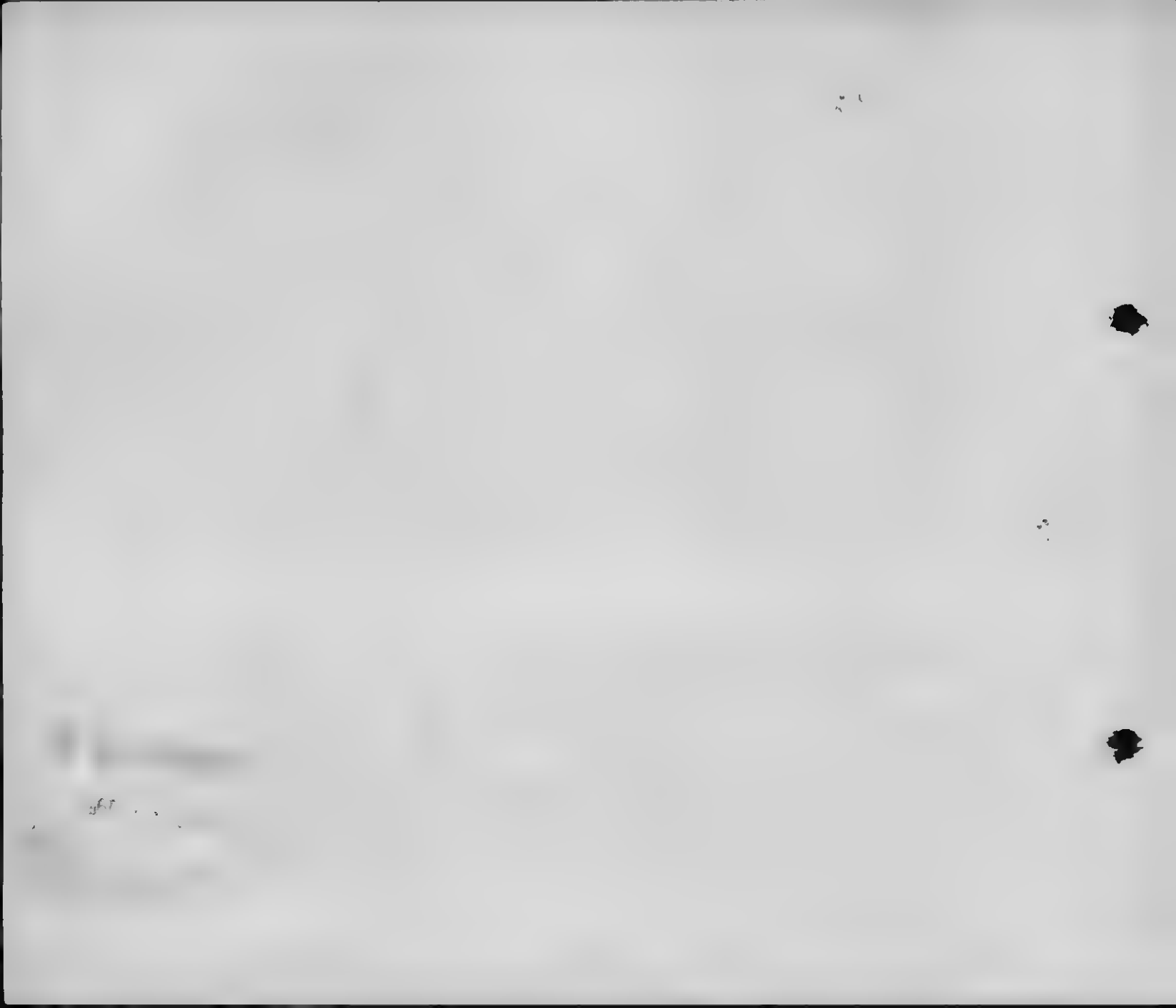
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8296

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 6

08262

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
<u>X</u> TOWN <u>Rural-near Danville</u>		<u>30 Yrs.</u>		TOWN <u>Rural-near-Danville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #3 Keyser, W. Va.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. #3 Keyser, W. Va.</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Sarah</u>		<u>Rosella</u>		<u>Ravenscroft</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>female</u>		<u>white</u>		<u>widow</u>		<u>Aug. 31-1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: IF UNDER 1 YEAR, IF UNDER 24 HRS.		4. DATE OF DEATH	
<u>Housewife</u>				<u>77</u> yrs.		<u>Sept. 25 19 55</u>	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Avilton, Garrett Co., Md.</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MARDEN NAME:			
<u>Andrew Jackson</u>				<u>Charlotte Dawson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>if no</u>		<u>none</u>		<u>Keyser, W. Va.</u> <u>(daughter) Martha Ravenscroft, R.F.D. #3</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) ... <u>Myocardial failure</u>						Gradual ...	
Antecedent cause(s) (b) ... <u>Chronic myocarditis also had</u>						over 2	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) ... <u>arteriosclerosis with hypertention.</u>						years. ...	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE							
<u>H. V. Deming M.D.</u>				<u>H. V. Deming M.D.</u>			
CHIEF MEDICAL EXAMINER				DATE SIGNED			
DEPUTY MEDICAL EXAMINER				<u>Sept. 26/55</u>			
ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Sept. 27, 1955</u>		<u>Westview Cemetery, Westview, Md.</u>		<u>Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 26, 1955</u>		<u>McGowan C. Kelly</u>		<u>John G. Stager</u>		<u>"</u>	
<u>Sept. 28-1955</u>							



1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08290

8263

CERTIFICATE OF DEATH

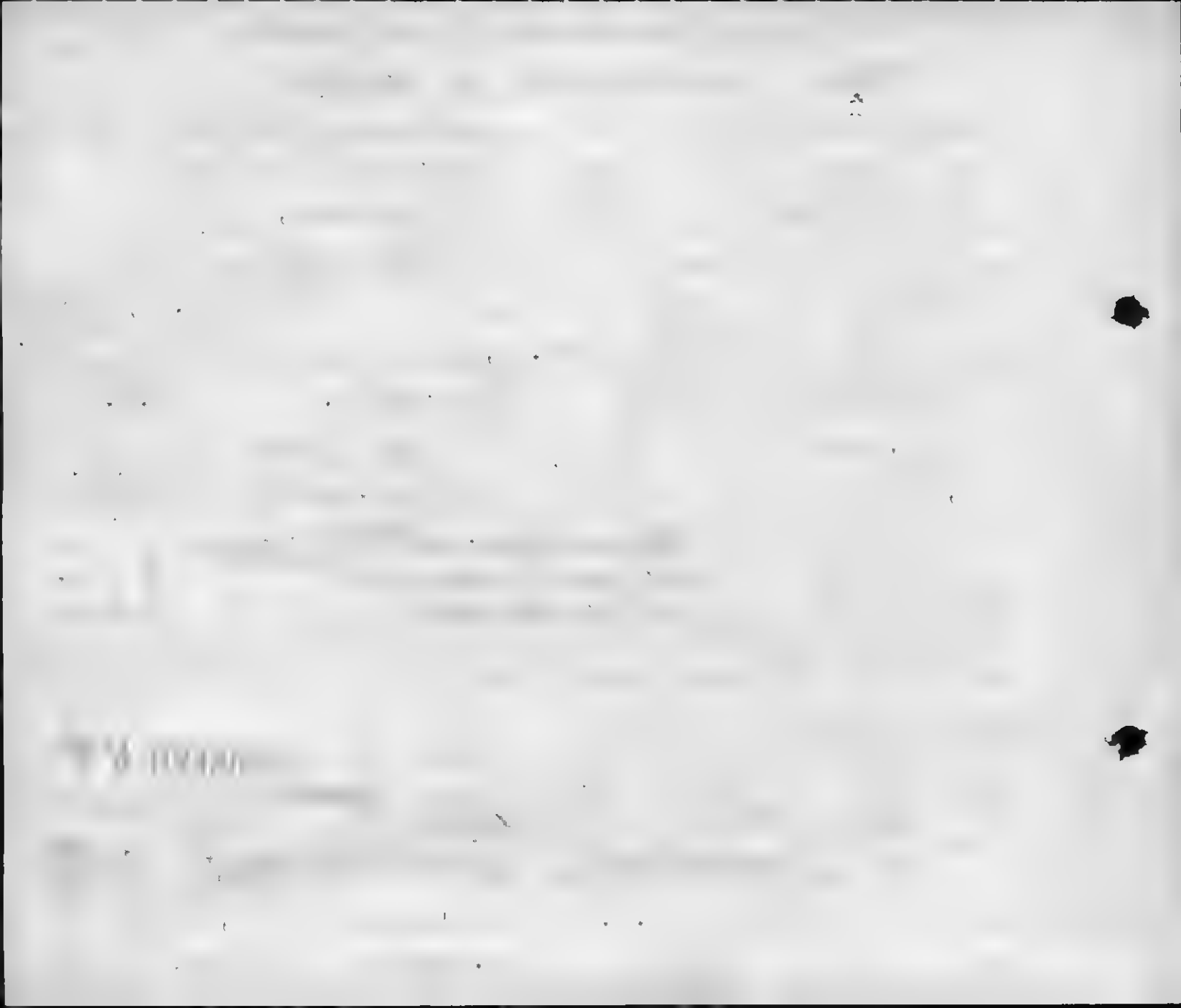
Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland,</u>				TOWN <u>Cumberland,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Ridgeway Terrace</u>				STREET ADDRESS (If rural give location) <u>15 Ridgeway Terrace</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY CATHERINE ROSE</u>				4. DATE OF DEATH <u>Sept. 30, 1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Nov. 20, 1880</u>	
				9. AGE last birthday <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John H. Diggs</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hammersmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Theodore M. Rose 15 Ridgeway Terrace Cumberland, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Chronic myocarditis & Myocardial degeneration</u>				<u>12 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial hypertension</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>				<u>3 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>?</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 3, 1955</u> , to <u>Sept 30, 1955</u> , that I last saw the deceased alive on <u>Sept 28, 1955</u> , and that death occurred at <u>101</u> M. from the causes and on the date stated above.							
SIGNATURE <u>R. H. Lewicki, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Cumberland, Md.</u> DATE <u>9/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>S. S. Peter & Paul's</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. - Mantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Maryland</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 4

8264

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CUMBERLAND</u>		LENGTH OF STAY (In this place) <u>9 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,</u>				STREET ADDRESS (If rural give location) <u>517 WOODSIDE AVE.,</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>PATRICK E. RYAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 6 19 55</u>			
5. SEX <u>74</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>May 31, 1873</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD RYAN</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HOGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-5206</u>		17. INFORMANT & ADDRESS <u>Julia W. Morris 517 Woodside Ave</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>					<u>15 days?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Disease, Coronary Artery Disease and</u>					<u>??</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Auricular Fibrillation</u>					<u>?</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Gangrene, left foot</u>					<u>15 days?</u>	
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>August 28, 1955</u> to <u>Sept. 6, 1955</u> , that I last saw the deceased alive on <u>Sept. 6, 1955</u> , and that death occurred at <u>10:00AM</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		M.D. <u>50 Pershing St. Cumberland, Md.</u>	
ADDRESS (Street, city, town, state)		DATE SIGNED <u>9/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cem.</u>		LOCATION (City, town, or county) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>Sept. 8, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarrelli</u>	

VS AISC 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



8265

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE PENN.		COUNTY BEDFORD	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		1 DAY		TOWN HYNDMAN		75-X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL MEMORIAL AVENUE							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
MRS BLANCHE SATZER				SEPT. 23,		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	Nov. 6, 1892	62 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				CUM House		PENN.	
12. CITIZEN OF WHAT COUNTRY?				12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE				XMSX U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES MASON				ANNA KENDALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
No				None		MEMORIAL HOSPITAL, CUMBERLAND, MD.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				Chronic Cardiovascular and Arteriosclerosis			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 1955 to Sep 23, 1955, that I last saw the deceased alive on Sep 23, 1955, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Harvey H. Zeigler M.D.				Hyndman, Pa.		9/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 26, 1955		Hyndman Cemetery		Hyndman, Pa.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 25, 1955		Walter R. Brant, M.D.		Harvey H. Zeigler, Hyndman, Pa.			

INSTRUCTIONS

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2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 1011



08293

8266

CERTIFICATE OF DEATH

Reg. Dist. No. 4

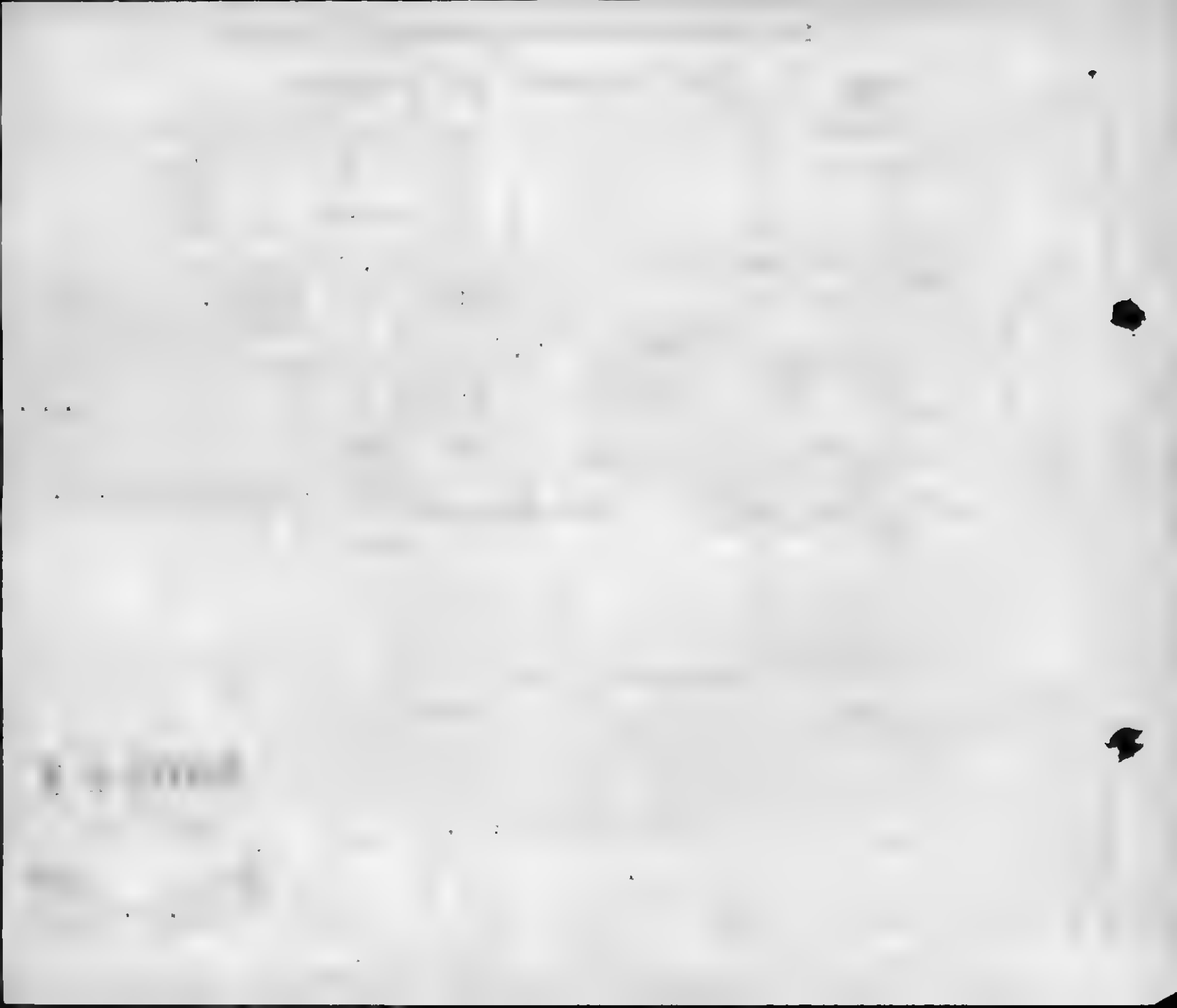
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		69 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60 MEMORIAL HOSPITAL				535 N. CENTRE STREET			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
ELIZABETH SHIELDS				SEPT. 12 1955		81 yrs.	
6. SEX	7. COLOR OR RACE	8. SINGLE, MARRIED, WIDOWED, D.VORCED, (Specify)	9. DATE OF BIRTH	10. AGE last birthday		IF UNDER 1 YEAR	
FEMALE	WHITE	WIDOW	JAN. 4 1874	81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Wife		Own House		WEST VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SAMUEL FULLER				HATTIE SPOERLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
493X IMMEDIATE CAUSE (A)				Pneumonia			
ANTECEDENT CAUSE(S) DUE TO				Septicemia			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/5 , 19 55 , to 9/12 , 19 55 , that I last saw the deceased alive on 7/11 , 19 55 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
M.D. 486 N. Centre St. Cumberland				9/12/55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept 14/55		Spurling Cemetery		Junction, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 12, 1955		Walter R. Frantz, M.D.		Meryl Combs		Romney, W. Va.	

INSTRUCTIONS

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2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Alleghany</u>	MARYLAND	STATE <u>M d.</u>	COUNTY <u>Alleghany</u>
CITY (If outside corporate limits, write RURAL or give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Cumberland</u>	<u>9 hrs.</u>	TOWN <u>Cumberland rural</u>	<u>x</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>Memorial Hospital</u>		<u>R.F.D. #1 LaVale</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Clifton</u>	(Middle) <u>Vermont</u>	(Last) <u>Shriver</u>	(Month) <u>Sept.</u> (Day) <u>6</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Jan. 10-1915</u>
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	9b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday:	10. IF UNDER 1 YEAR (Months) Days (Hours) Min.
<u>Retired power worker</u>	<u>Cumberland Brewing</u>	<u>40</u> yrs.	<u>13</u> yrs.
11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>Eckhart, Md.</u>	<u>U.S.A.</u>		
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>George Shriver</u>		<u>Lulu Rophann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>Yes</u>		<u>220-10-9291</u>	
17. INFORMANT & ADDRESS:			
<u>Memorial Hospital records.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
201X Immediate cause (a) <u>Hodgkins disease (abdominal)</u> DUE TO		<u>?</u>
Antecedent cause(s) (b) <u>Pulmonary infarct</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arthritis</u>		<u>13 yrs.</u>
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>H. V. Deming M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Sept 7-1955</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>Sept. 9, 1955</u>	<u>Hope Cemetery</u>
LOCATION (City, town, or county) (State)		
<u>Donacoona, Maryland</u>		
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>Sept. 9, 1955</u>	<u>Walter R. Frank, M.D.</u>	<u>John J. Kager, Cumberland, Maryland</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08295

8297

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Ellerslie</u>		<u>15 years</u>		TOWN <u>Ellerslie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Moses Edward Shroyer</u>				<u>Sept. 27, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Feb. 22, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Motorman</u>		<u>Street car</u>		<u>Hyndman, Pa. RD#1</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Moses E. Shroyer</u>				<u>Jane Elizabeth Mary Logsdon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>George W. Shroyer, Ellerslie, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>10 yrs</u>			
IMMEDIATE CAUSE (A)				<u>Chronic Myocardiosis</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>45</u> , to <u>Sept. 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 27</u> , 19 <u>55</u> , and that death occurred at <u>Hyndman</u> , M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Arthur L. Lippert, M.D.</u>				<u>Hyndman, Pa.</u>		<u>Sept. 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 30, 1955</u>		<u>Cooks Mills Cemetery</u>		<u>Hyndman, Pa. RD#1</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Sept 28, 55</u>		<u>J. L. Wolfe</u>		<u>Harvey H. Zeigler</u>		<u>Hyndman, Pa.</u>	



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8268

CERTIFICATE OF DEATH

08296

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>7 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>408 Goethe Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles Perry Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 16 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>March 23, 1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. P. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Anne Hoebrook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, or, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. C. P. Smith, 408 Goethe St.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) DUE TO (C)				<u>Chronic Myocarditis</u> <u>Cerebral Arteriosclerosis</u> <u>Chronic Nephritis</u> <u>Senile psychosis.</u>			
19a. DATE OF OPERATION <u>1949</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 15, 1955</u> to <u>Sept. 16, 1955</u> , that I last saw the deceased alive on <u>Sept. 15, 1955</u> , and that death occurred at <u>7:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James H. Hean, M.D.</u>				ADDRESS (Street, city, town, state) <u>49 Greene St.</u>		DATE SIGNED <u>9-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eckhart, Maryland</u>	
24. REC'D BY REGISTRAR <u>Sept 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland, Maryland</u>	

1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

Figure 1

8298

CERTIFICATE OF DEATH

Reg. Dist. No. *10*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Allegany</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Allegany</i>	
CITY (if outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Barrelville</i>				TOWN <i>Barrelville</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>At Home, Barrelville, Md.</i>				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>MELVIN CLEBERN SUTHERLEN</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>September 6 1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 26, 1889</i>	9. AGE last birthday <i>63</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hugo, Oklahoma</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN SUTHERLEN</i>				14. MOTHER'S MAIDEN NAME <i>FLORENCE HANNA</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>452-14-2152</i>		17. INFORMANT & ADDRESS <i>Mrs. Frank Johns, Barrelville, Md</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Myocarditis - Related Heart</i>						<i>October 1954</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Pulmonary Edema</i>						<i>1 year</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Bronchitis - trachea</i>						<i>5 years</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>January 7, 1950</i> , to <i>7-6</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7-6</i> , 19 <i>55</i> , and that death occurred at <i>7:04</i> M., from the causes and on the date stated above.							
SIGNATURE <i>William L. Massey</i>				ADDRESS (Street, city, town, state) <i>107 Savage Ind.</i>		DATE SIGNED <i>7-7-1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 8, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Gook's Cemetery</i>		LOCATION (City, town, or county) (State) <i>Mr. Wollersburg, Pennsylv</i>	
24. READ BY REGISTRAR <i>Sept. 7, 1955</i>		REGISTRAR'S SIGNATURE <i>William L. Massey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Hafer</i>		ADDRESS <i>Cumberland, Maryland</i>	

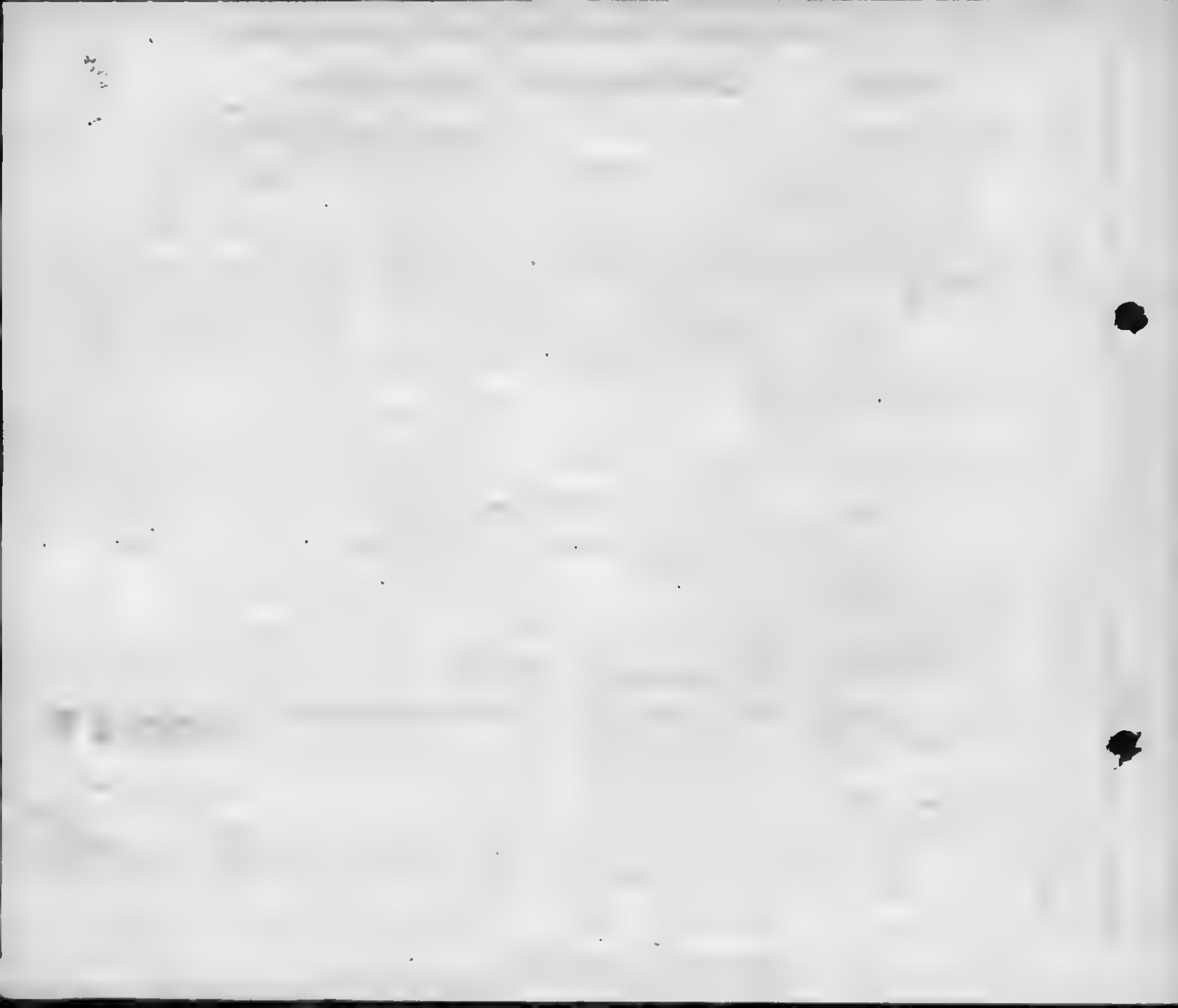
INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1. Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08298

8269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

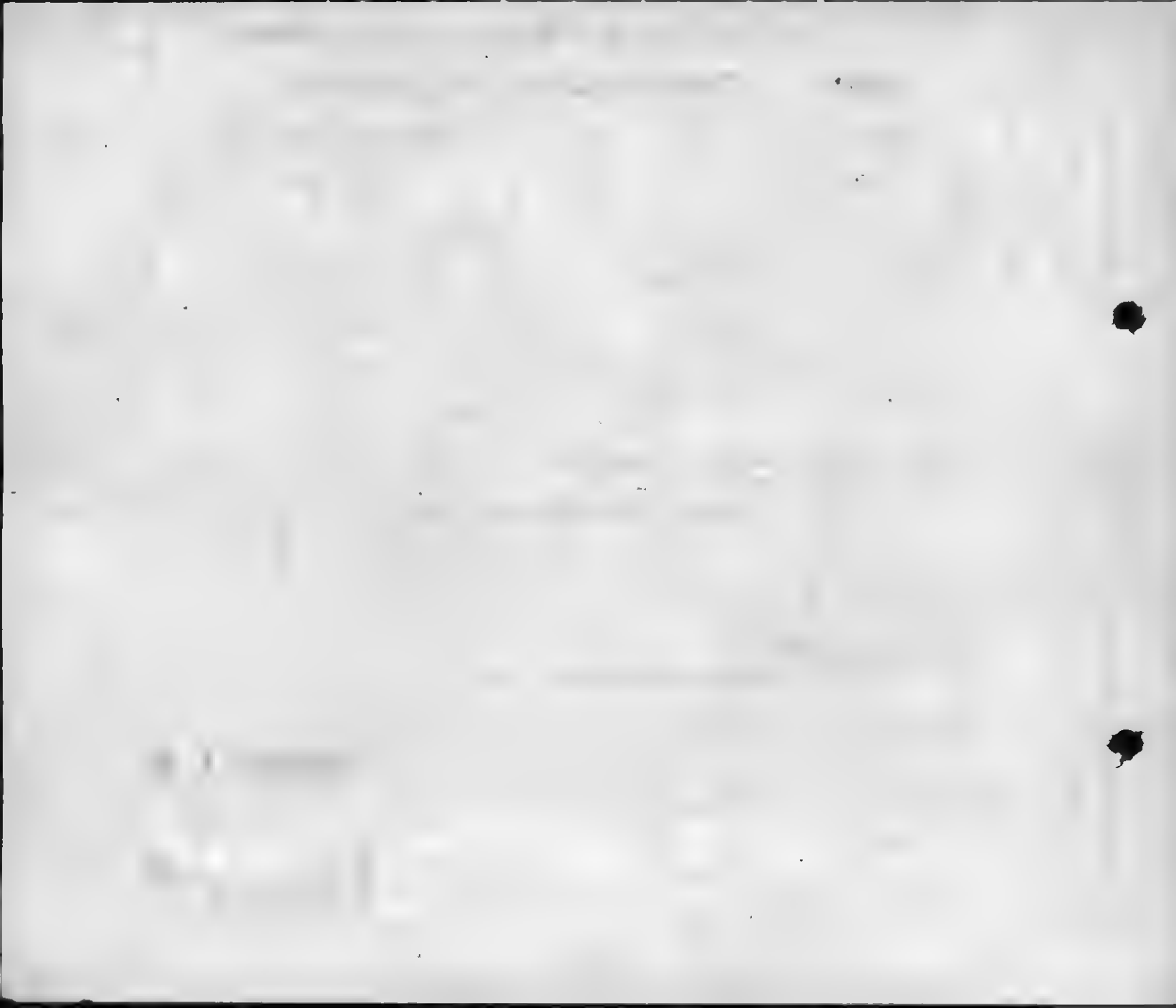
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegheny		MARYLAND		STATE Maryland		COUNTY Allegheny	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Cumberland		2 yrs		TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 345 Frederick Street				STREET ADDRESS (If rural give location) 345 Frederick Street			
3. NAME OF DECEASED (Type or Print) MOSES (First) TAYLOR (Middle) TAYLOR (Last)				4. DATE OF DEATH (Month) (Day) (Year) Sept. 7 19 55			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 10, 1882	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Met. Janitor		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY TAYLOR Tire Co.				14. MOTHER'S MAIDEN NAME JANE WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 220-10-2610		17. INFORMANT & ADDRESS Mrs. Katie Taylor, Cumberland, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Coronary Artery Disease</i>				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) <i>arteriosclerosis of the heart</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 6</i> , 19 <i>55</i> , to <i>Sept 7</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Sept 6</i> , 19 <i>55</i> , and that death occurred at <i>4:15</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>B. M. Schindler</i>				DATE SIGNED <i>9/8/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 9, 1955		NAME OF CEMETERY OR CREMATORY Sumner Cemetery		LOCATION (City, town, or county) Cumberland, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Walter R. Frantz, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS A15C 1-55 10M



1 Without corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8270

CERTIFICATE OF DEATH

08299

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ALLEGANY	MARYLAND	STATE MARYLAND	COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN CUMBERLAND	2 DAYS	TOWN FROSTBURG	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
MEMORIAL HOSPITAL		23 BROADWAY	

3. NAME OF (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANNIE THOMAS	SEPTEMBER 4 1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.
FEMALE	WHITE	SINGLE	AUGUST 10 - 1976	79 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Home	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN THOMAS	ANN HOPKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	MEMORIAL HOSPITAL - CUMBERLAND, MD.

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
151X IMMEDIATE CAUSE (A)	Cancer stomach, advanced			Approx 2 yrs
ANTECEDENT CAUSE(S) DUE TO	with post operative shock			18 hours
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Sep 3, 1955	Advanced Ca Stomach with diffuse metastases	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep 2, 1955, to Sep 4, 1955, that I last saw the deceased alive on Sep 4, 1955, and that death occurred at 6:10 A.M. from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	DATE SIGNED
Burial		9-6-55	Fly Memorial Park	Frostburg Md	Sep 4 '55
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
	Wm R. Frank, M.D.	J. P. Querst		Frostburg Md	

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



8271

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND		4 DAYS		TOWN FLINSTONE, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
MEMORIAL HOSPITAL				RT. #1			
MEMORIAL AVE.							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
MRS. EMMA A. TWIGG				SEPT. 1 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	WIDOWED	NOV. 27, 1874	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housekeeper at home					MARYLAND		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ROSS TWIGG				LUCY SRRINGSTEEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		none		MEMORIAL HOSPITAL, CUMBERLAND, MD.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				Cerebral Vascular Accident			
ANTECEDENT CAUSE(S) (B)				Congestive Heart Failure			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (C)				Arteriosclerotic Cerebrovascular Disease			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 19 55, to Sept 1 55, that I last saw the deceased alive on Sept 1 55, and that death occurred at 8:20 PM, from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR				DATE SIGNED			
[Signature]				9/3/55			
ADDRESS (Street, city, town, state)				M.D. 133 Virginia Ave Cumberland, Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		9/4/55		Oldtown Cemetery		Oldtown Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept 4, 1955		[Signature]		H. Lee Silcox		Cumberland, d.	

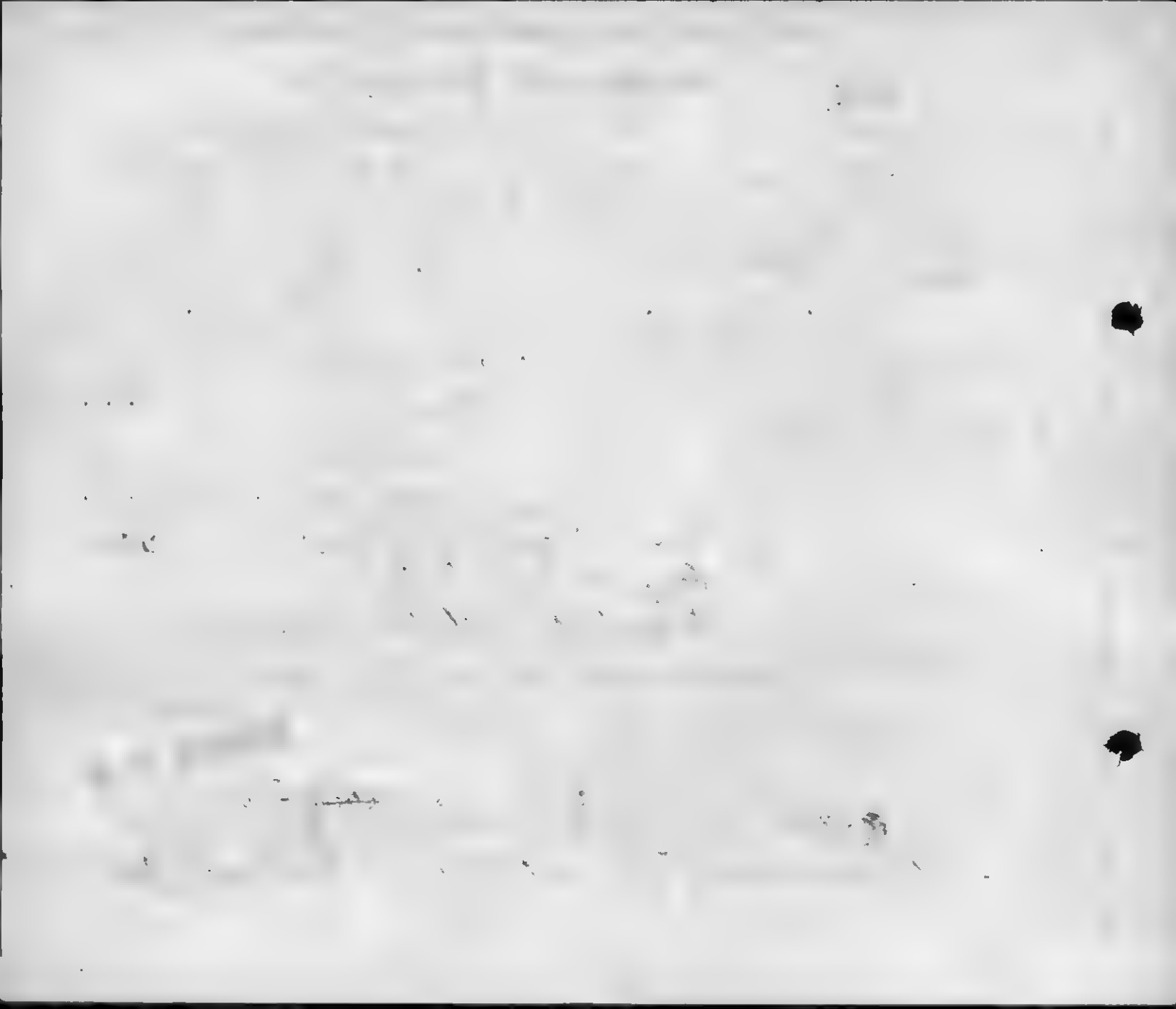
1. Within corporate limits

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



8272

CERTIFICATE OF DEATH

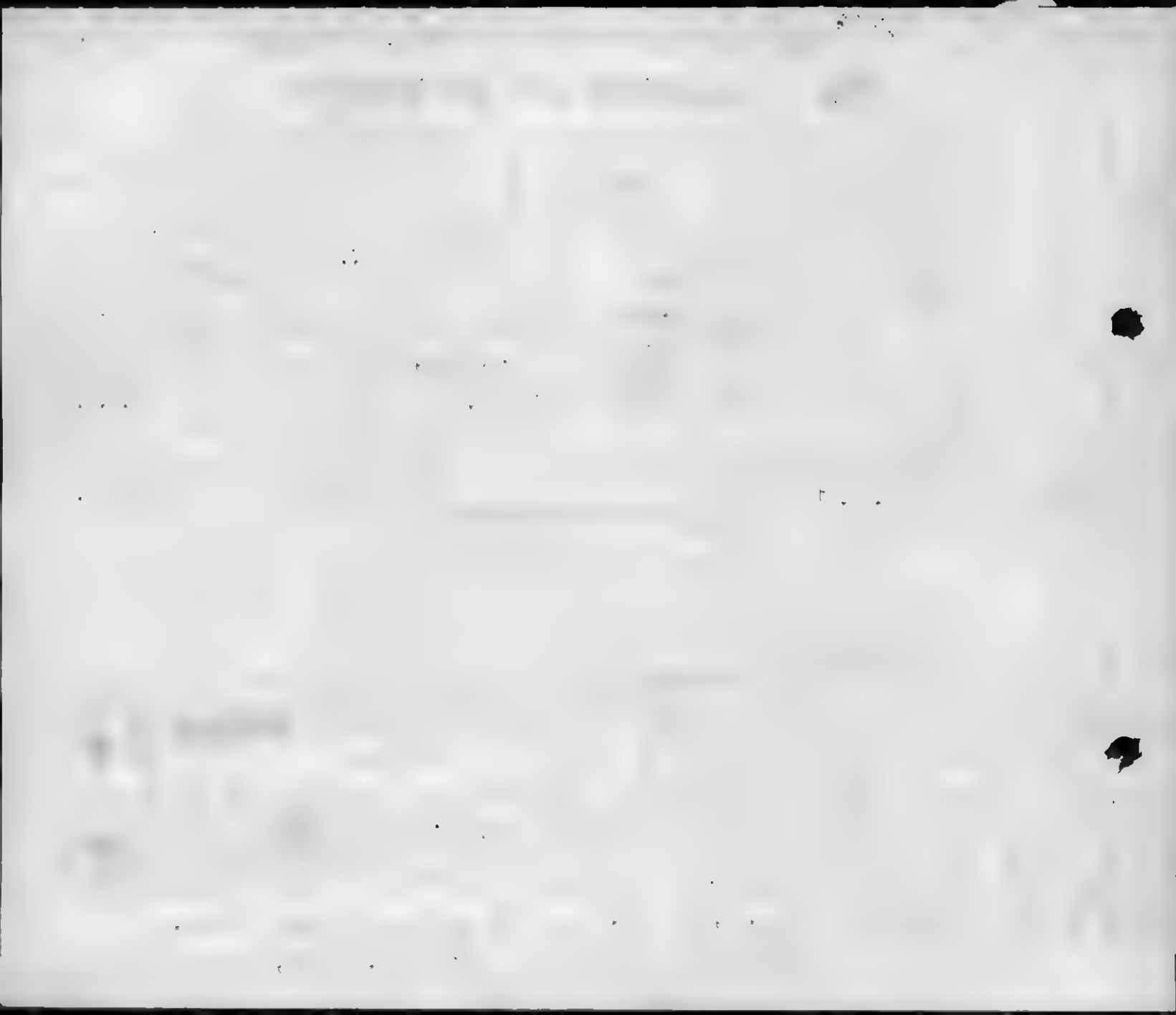
Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		MARYLAND		STATE MARYLAND		COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND		LENGTH OF STAY (in this place) 29 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CUMBERLAND, rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL				STREET ADDRESS RT. #1		(If rural give location) CUMBERLAND	
3. NAME OF (First) (Middle) (Last) CARL ELTON VAN AUSDALE				4. DATE (Month) (Day) (Year) DEATH SEPTEMBER 1, 1955			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH SEPT. 16, 1898	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY WHITE HAINES OPTICAL CO.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SCOTT VAN AUSDALE				14. MOTHER'S MAIDEN NAME SARAH BAXTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 11. 11. 1		17. INFORMANT & ADDRESS MEMORIAL HOSPITAL -CUMBERLAND, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A)		Colinomatosis				2 years	
ANTECEDENT CAUSE(S) DUE TO (B)		Colinoma Stomach				2 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 22 Aug. 55		19b. MAJOR FINDINGS OF OPERATION Colinoma stom. with melanosis				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 28 Aug. 55, to 1 Sept. 1955, that I last saw the deceased alive on 1 Sept. 1955, and that death occurred at 10:35 P.M. from the causes and on the date stated above.							
SIGNATURE W. A. Van Osma				ADDRESS (Street, city, town, state) Cumberland, Md.		DATE SIGNED 3 Sept. 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Sept. 5, 1955		NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		LOCATION (City, town, or county) (State) Cumberland, Md.	
24. REC'D BY REGISTRAR DATE Sept. 4, 1955		REGISTRAR'S SIGNATURE Walter L. Frantz, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



Outside of
City Limits

8273

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08302

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Allegany		STATE		Md.	
CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN (Rural) Cumberland		COUNTY		Allegany	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		P.O. 3 Bowmans Addition		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN (Rural) Cumberland	
3. NAME OF DECEASED:		(First) George		(Middle) Washington		(Last) Walker	
4. DATE OF DEATH		Sept. 27		5. AGE last birthday:		74	
6. SEX:		male		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		Married	
8. DATE OF BIRTH:		Sept. 29-1880		9. AGE last birthday:		74	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, (Specify if retired):		Laborer		10b. KIND OF BUSINESS OR INDUSTRY:		W.P.A.	
11. BIRTHPLACE (State or foreign country):		Lost River, W. Va.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME:		Jake Walker		14. MOTHER'S MAIDEN NAME:		Jamina Combs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		no		16. SOCIAL SECURITY No.:		None	
17. INFORMANT & ADDRESS:		Memorial Hospital records.		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		2. MEDICAL CERTIFICATION	
420.1 Immediate cause		Coronary occlusion	
Antecedent cause(s)		Coronary sclerosis also had	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		Arteriosclerosis with hypertension	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H.V. Downing M.D. H.V. Downing M.D. M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. DATE SIGNED Sept. 27/55

23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept. 29, 1955		Stoney Creek Cemetery		Romney, West Virginia	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Sept. 28, 1955		Walter R. Fandy, M.D.		Brush Funeral Home		Romney, W. Va.	

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of age is especially important. Physicians: please write the causes of death clearly and legibly.



8290

CERTIFICATE OF DEATH

Reg. Dist. No. 9

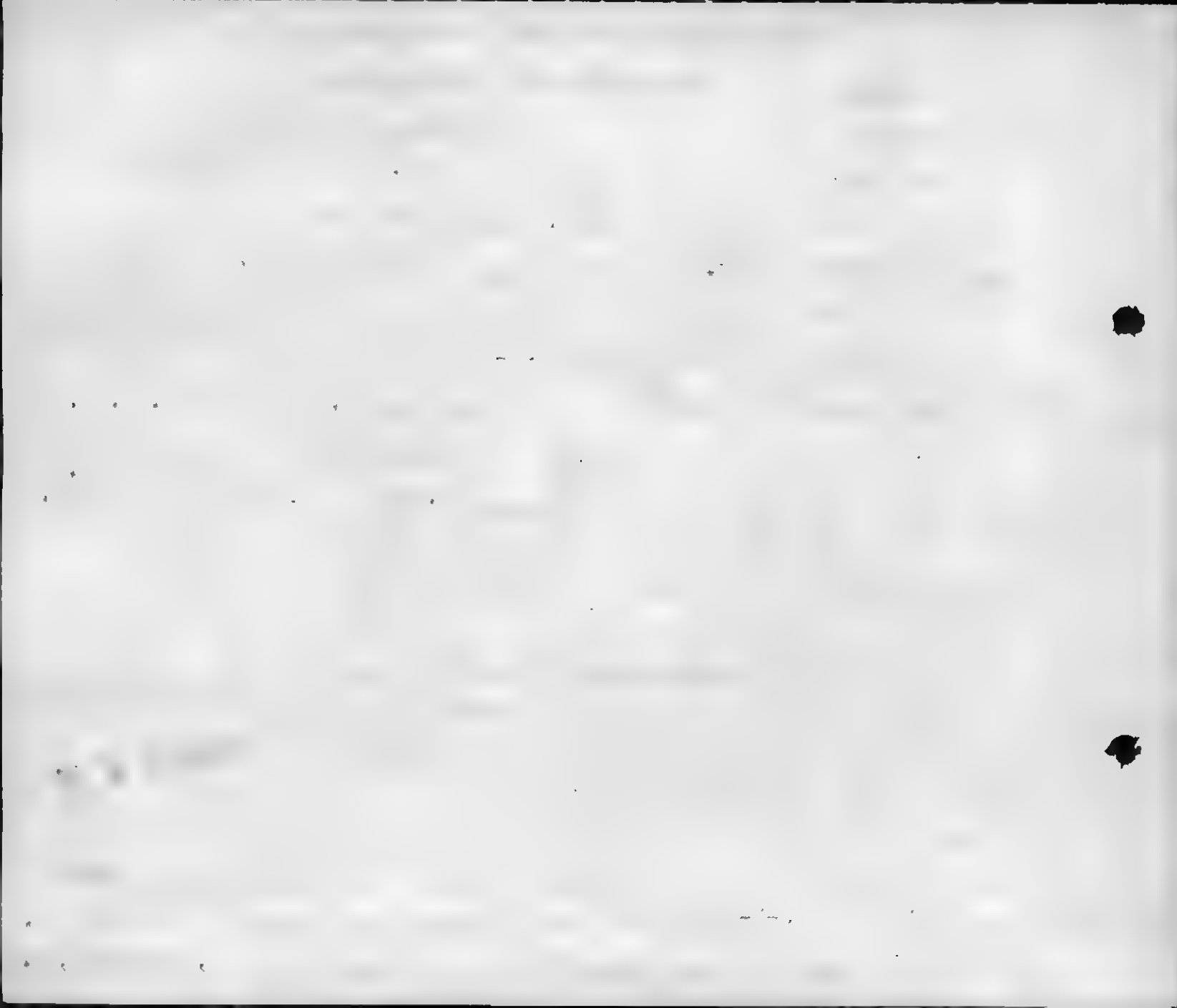
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frostburg</u>		<u>50 yrs.</u>		TOWN <u>Frostburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>47 Linden St.</u>				STREET ADDRESS (If rural give location) <u>47 Linden St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Ward</u>				4. DATE OF DEATH <u>8 29 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>10-9-1872</u>	
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Jennings Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jonas Folk</u>				14. MOTHER'S MAIDEN NAME <u>Suzanna Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Frostburg, Md.</u>	
18. MEDICAL CERTIFICATION				19. DATE OF OPERATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>				<u>10 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-Sclerotic Ch. V disease</u>				<u>10 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>				<u>10 yrs.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				<u>5 yrs.</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. al work <input type="checkbox"/> Not white at work <input type="checkbox"/>				21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1</u> , 19 <u>30</u> , to <u>8-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>55</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>H. H. D. D.</u>				DATE SIGNED <u>8/31/55</u>			
ADDRESS (Street, city, town, state) <u>Frostburg Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-1-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR <u>9-2-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Roe</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pearl H. Mattingly</u>		ADDRESS <u>Frostburg, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Allegany</u>	MARYLAND	STATE <u>Id.</u>	COUNTY <u>Allegany</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cumberland</u>	LENGTH OF STAY (in this place) <u>45 years</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cumberland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>337 Davidson St.</u>		STREET ADDRESS (If rural, give location) <u>337 Davidson St.</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Adelaide</u>	(Middle) <u>Catherine</u>	(Last) <u>Ways</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>June 20-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	9. AGE last birthday: <u>82</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Cumberland, Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jacob D. George</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret C. Wineow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>(daughter) Georgie Ways, Cumberland, Id.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO		<u>sudden</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>Coronary sclerosis.</u> DUE TO		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>6</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>H. V. Downing M.D.</u> M. D. CHIEF MEDICAL EXAMINER <u>H. V. Downing M.D.</u> DEPUTY MEDICAL EXAMINER <u>H. V. Downing M.D.</u> ASSISTANT MEDICAL EXAM. * <u>Sept. 6-1955</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>Sept. 9, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>Greenmount Cemetery</u>
LOCATION City, town, or county (State) <u>Cumberland, Maryland</u>	DATE REC'D BY LOCAL REG.: <u>Sept. 7, 1955</u>	REGISTRAR'S SIGNATURE: <u>Walter R. Prantz, M.D.</u>
24. FUNERAL DIRECTOR: <u>Charles L. George, "</u>		ADDRESS: <u>"</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



8275

CERTIFICATE OF DEATH

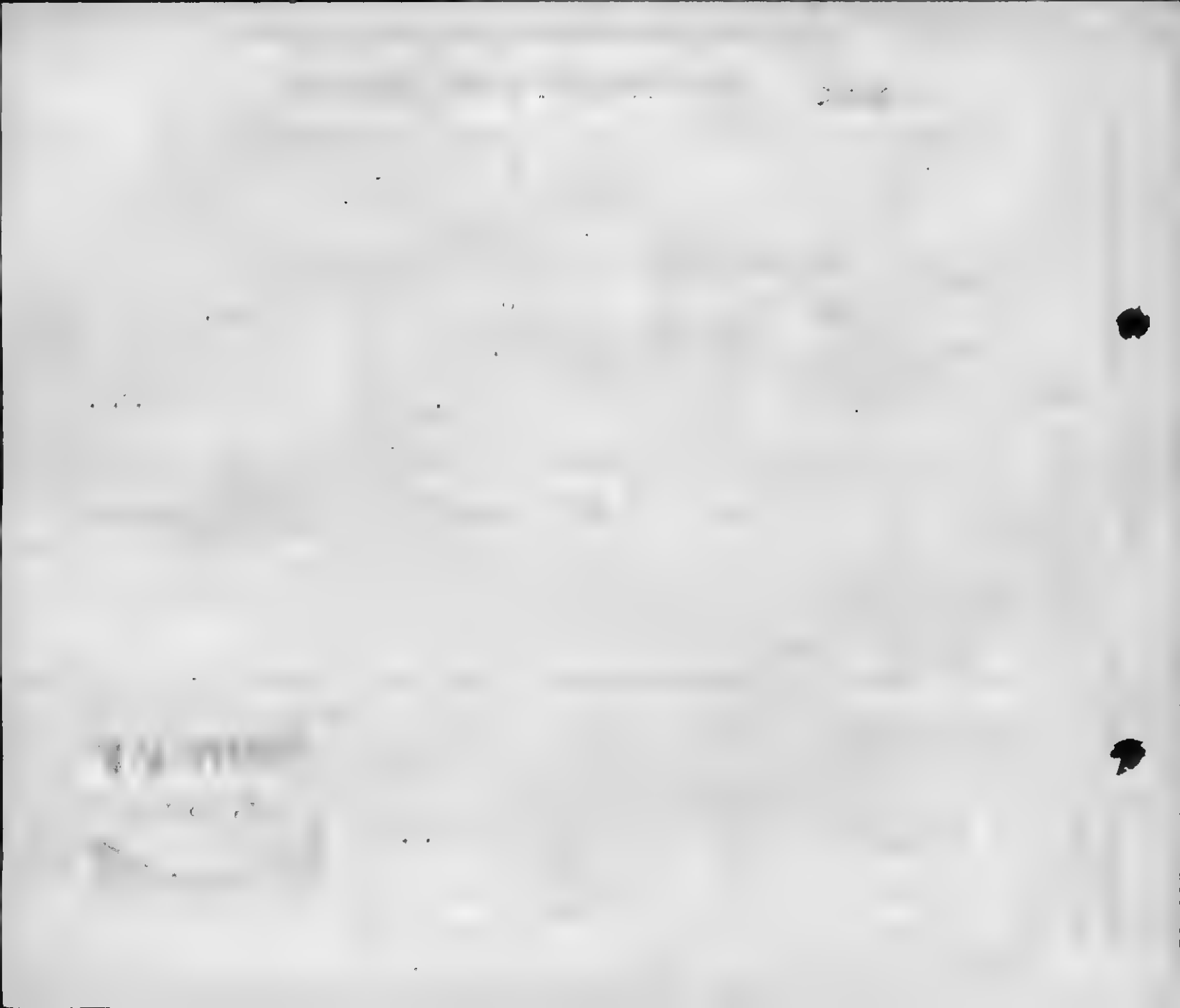
Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY				STATE MARYLAND COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN CUMBERLAND		19 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				605 COLUMBIA AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) EDNA (Middle) F. (Last) WILT				(Month) SEPT. (Day) 13 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEMALE	WHITE	MARRIED	SEPT. 5, 1904	51 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife			Own home		MD. Twenty First Bridge		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DAYTON, EDWARD				DAWSON, LUCY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		NONE		MEMORIAL HOSPITAL			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
441X IMMEDIATE CAUSE (A) Uremia							
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension - 170/100							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cardiac insufficiency							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 25 Aug 1955 to 12 Sept , 19 55 , that I last saw the deceased alive on 12 Sept , 19 55 , and that death occurred at 1:15 A.M. the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
John J. Hafer				113 Beechcroft Court, Baltimore, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Sept 16, 1955		Philos Cemete		Westernport, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
Sept. 15, 1955		Walter R. Frank, M.D.		John J. Hafer, Cumberland, Maryland			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.



INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08306

8276

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MD.</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>2 days</u>		CITY OR TOWN <u>Lonaconing</u>		CITY OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Dudley Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Maude</u> (First) <u>Yates</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) <u>Sept.</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 19th. 1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Barton, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Mowbray</u>				14. MOTHER'S MAIDEN NAME <u>Jane Ann - Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Elizabeth Yates, Lonaconing, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION (Daughter)			
443X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2d</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>				3-4 yr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10, 1955</u> , to <u>10 Sept. 55</u> , that I last saw the deceased alive on <u>10 Sept. 1955</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George Eichhorn</u> M.D.				DATE SIGNED <u>9-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery, Moscow, MD.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Sept. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Walter R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>			

CERTIFICATE OF DEATH

8278

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

RECEIVED

BUREAU V.

SEP 18 1965

RECEIVED

CERTIFICATE OF DEATH

08307

Reg. Dist. No. 4

8277

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY ALLEGANY		STATE MARYLAND		COUNTY ALLEGANY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN CUMBERLAND, MD.		32 DAYS		TOWN CUMBERLAND			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
MEMORIAL HOSPITAL				336 AVIRETT AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) SUSAN (Middle) Lambie (Last) YEAGER				(Month) SEPT. (Day) 26 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday		IF UNDER 1 YEAR	
FEMALE	WHITE	WIDOWED	JAN. 7, Jan. 5, 1864	91 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		SCOTLAND Edinboro		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Osborne				Jean ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		None		MEMORIAL HOSPITAL			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A)				Cerebral Thrombosis		From	
ANTECEDENT CAUSE(S) DUE TO				Generalized Arteriosclerosis		8-27-55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B)			
STATING UNDERLYING CAUSE LAST.				(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-23-55 , 19 55 , to 9-26-55 , 19 55 , that I last saw the deceased alive on 9-23-55 , 19 55 , and that death occurred at 5:10 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
W. F. Williams, M.D.		Cumberland, Md.		9-26-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9/28/55		Rose Hill Cem.		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Sept. 28, 1955		Walter R. Hantz, M.D.		H. Wayne George		Cumberland, Md.	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1955

CERTIFICATE OF DEATH

1955

NAME OF DECEASED: JOHN J. ROY
 SEX: MALE AGE: 35 YEARS
 RACE: WHITE DATE OF BIRTH: 1920
 PLACE OF BIRTH: NEW YORK

DECEASED AT: 300 AVENUE A
 CITY: NEW YORK STATE: NEW YORK
 DATE OF DEATH: SEP 20 1955

CAUSE OF DEATH: HEART DISEASE
 ICD-9 CODE: 410
 PLACE OF DEATH: HOME

SIGNATURE OF PHYSICIAN: [Signature]
 NAME: DR. J. J. ROY
 ADDRESS: 300 AVENUE A

NAME OF FUNERAL HOME: [Blank]
 ADDRESS: [Blank]
 CITY: [Blank] STATE: [Blank]

BUREAU V. S.

SEP 20 1955

RECEIVED

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND.
 TO BE FILED IN THE DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND.
 TO BE FILED IN THE DEPARTMENT OF HEALTH, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND.